

This electronic thesis or dissertation has been downloaded from the King's Research Portal at <https://kclpure.kcl.ac.uk/portal/>



Special Medicine: Producing Doctors at the All India Institute of Medical Sciences (AIIMS)

Ruddock, Anna Louise

Awarding institution:
King's College London

The copyright of this thesis rests with the author and no quotation from it or information derived from it may be published without proper acknowledgement.

END USER LICENCE AGREEMENT



Unless another licence is stated on the immediately following page this work is licensed

under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International

licence. <https://creativecommons.org/licenses/by-nc-nd/4.0/>

You are free to copy, distribute and transmit the work

Under the following conditions:

- Attribution: You must attribute the work in the manner specified by the author (but not in any way that suggests that they endorse you or your use of the work).
- Non Commercial: You may not use this work for commercial purposes.
- No Derivative Works - You may not alter, transform, or build upon this work.

Any of these conditions can be waived if you receive permission from the author. Your fair dealings and other rights are in no way affected by the above.

Take down policy

If you believe that this document breaches copyright please contact librarypure@kcl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

**SPECIAL MEDICINE:
PRODUCING DOCTORS AT THE ALL
INDIA INSTITUTE OF MEDICAL SCIENCES
(AIIMS)**

**ANNA L. RUDDOCK
0200945**

**PHD
ANTHROPOLOGY**

ABSTRACT

This thesis is an anthropological study of the All India Institute of Medical Sciences (AIIMS), with a primary focus on undergraduate, or MBBS, education. Established in 1956, AIIMS is an enormous government-funded hospital, anomalous in the public healthcare landscape for employing many of India's most respected doctors, who consistently provide a high standard of free or low-cost care to patients of low socioeconomic status. It also occupies an unassailable position atop the hierarchy of Indian medical education. AIIMS is a postcolonial institution, with origins in a colonial proposition, informed by global expertise, and realized with the support of international donors.

Despite its profile, AIIMS has received little attention from social scientists. The same is true of medical education in India more broadly. Attending to these lacunae, I position my thesis in relation to literatures on hospital ethnography, and the training of health professionals in the Global South, as well as attending to other determinants of students' experiences, including the dynamics of reservation-based difference, and their conceptions and experiences of aspiration and attainment. My analysis proceeds from an understanding of the All India Institute as simultaneously insulated from, permeated by, and complicit in the sociomedical landscape beyond its gates. Maintaining this perspective through a series of ethnographic chapters, I interrogate what is contained within the description of AIIMS and its students as 'the best'. How is 'the best' defined and experienced? How does it inform articulations of aspiration and excellence, at global, national, and individual levels? And what implications might the ways in which India's 'best' young doctors are produced contain for the politics and practice of health and medicine?

CONTENTS

ABSTRACT	2
CONTENTS	3
LIST OF TABLES	5
LIST OF MAPS	6
ACKNOWLEDGEMENTS	7
1. INTRODUCTION: ‘BUT AIIMS IS AIIMS...’	8
‘AIIMS is AIIMS’	10
Situating the study	15
A hospital with a college attached	19
<i>Corruption talk</i>	22
<i>Resources</i>	24
...And a college with a hospital attached	26
Medicine beyond the gates	30
<i>Illness and infrastructure</i>	33
<i>Producing doctors</i>	38
Structure	41
2. ‘ARE YOU A SPY?’: ON METHODOLOGY	44
Accessing the Institute	45
The students	50
On hospital ethnography in particular	54
Ethics	56
Disability and fieldwork	59
3. IMAGINING AN INSTITUTION	62
<i>Recollections of the beginning (1) – Dr S</i>	64
Early institutions	66
The Bhore Committee	71
‘An Indian institute established in India, for the training of Indian workers by Indians’	73
<i>Recollections of the beginning (2) – Dr T</i>	77
Nehru, and the science of development	78
<i>Recollections of the beginning (3) – Dr V</i>	87
4. BEING THE BEST: GETTING IN	90
Why medicine?	91
‘Non-combustible data’: a brief history of mugging up	102
The ambiguities of education (or, the opportunity to aspire)	108
‘Lakhs of people just mugging stuff’	113
Taking the test	117
Rank, and the life of ‘biographical numbers...’	123
5. ‘FREEDOM’: BEING IN	133
‘The cream of people’	134
‘I think AIIMS is like heaven’: on freedom	138
<i>AIIMS as a liminal space</i>	141
‘The coasters’: the social life of reservations at AIIMS	144
<i>A history of protest</i>	144

<i>The Mandal Commission</i>	147
'Caste doesn't matter here'	152
'You have to fight your fight'	164
'Pull him up, pull him up, pull him up'	167
'Chaotic confrontations'	172
6. 'THE CLOSED WORLD OF WORDS': COMMUNICATING MEDICINE .	177
'You can build your own brain afterwards'	178
Communicating medicine	185
'The least you can do is listen to us'	186
Inset: Patient labour	195
<i>The hidden curriculum</i>	199
'The closed world of words'	203
<i>Dictating patienthood</i>	205
'We're not considering the person as a person'	213
7. 'AIIMS KILLED THE GP': ACHIEVEMENT, ASPIRATION, AND PRECLUDED FUTURES.....	219
The new conventional wisdom	220
<i>The fragmented body (1)</i>	222
'Patient demand'	223
<i>The fragmented body (2)</i>	229
The AIIMSonian's burden	229
<i>Remaining the best</i>	231
<i>The fragmented body (3)</i>	235
The state and doctor-citizens	235
<i>Community medicine</i>	241
<i>Waste, absence, lack</i>	243
Precluded futures	252
<i>Neha</i>	252
<i>Anjali</i>	254
<i>Dr B</i>	258
8. CONCLUSION: AIIMS IN IMAGINATION AND PRACTICE	261
BIBLIOGRAPHY	273

LIST OF TABLES

1. AIIMS snapshot 2013-14	5
2. Structured observation periods.....	5
3. In-depth semi-structured interviews.....	5

LIST OF MAPS

1. AIIMS patients' home locations.....	5
2. AIIMS students' home locations	5

ACKNOWLEDGEMENTS

While I have chosen and typed the final words that comprise this thesis, its overall production has been anything but a solo effort. Therefore, to:

The students and faculty of AIIMS Delhi (particularly ‘Dr B’), who facilitated and contributed to my research, and whose voices are at the heart of the thesis...

My supervisors, Dr Kriti Kapila and Professor Bron Parry...

Preeti Gulati, for sterling research assistance despite a confessed dislike of hospitals...

Arshima, Rama Baru, Susannah Deane, Peggy Froerer, Jocelyn Killmer, Family Misra, Virander Paul, Sankalp Pratap, Krishna Rao, Venkatesh Rao, Lily Shapiro, Kabir Sheikh, Nayantara Sheoran, Veena Sriram, Claire Wendland, and the many other fellow travellers who have supported and assisted me in various forms along the way...

My fellow Kingswallahs – Aasim, Abin, Avinash, Daniel, Debanjali, James, Jean-Thomas, Nishant, Raphaëlle, Saskia, Shankar, Smitana, Swapna, Vahit, Vipul – for understanding as only they can...

Old friends for cheerleading, and the more recent arrivals – Aadya, Alfie, Alys, Amaya – for keeping me in touch with the necessity of play...

Mum and Dad, for endless patience, warmth, and sustenance...

John, for his reliable bemusement at how I have chosen to spend the last four years...

And Suhas, my unexpected fieldwork souvenir, who made that, and this, and all of it, better...

THANK YOU.

CHAPTER 1. INTRODUCTION: 'BUT AIIMS IS AIIMS...'

'Is AIIMS a university with a great hospital attached, or a hospital with a medical college attached?' – Dr E, 17/02/15

I hold Dr E's question in my mind as I walk through the campus. I turn left inside the gates and stay within the rope that separates the narrow funnel of pedestrians from the stationary green and yellow autos that huddle out of the way of passing traffic. When a gap appears, I step sideways over the fraying red rope, suddenly conscious of the flamboyant movement as my legs slice through the air. It is late March, and the air is warm but not yet vibrating with the metallic heat of summer. I pause halfway across the concourse that extends out from the main outpatient department (OPD) building and scan the scene; as the sun gets stronger, there is greater competition for the shade cast by roof and walls. Small clusters of people sit on the floor, often on sheets made of recycled plastic packaging, bright with primary colours. Sometimes a patient is obvious – identifiable by frayed dressings on a wound, or a drainage bag lying on the floor beside a prone body – but not always. The inability to distinguish patients at first sight makes visible the fact of shared affliction – how illness experience and care-seeking extends beyond the skin of an individual to infiltrate the network of people that surround her.

Opposite, outside the temporary waiting hall that is being constructed, a few women have hung rinsed-out clothes to dry. As I watch, a security guard barks at them and gestures threateningly with his lathi towards the clothes. The women reluctantly pull the clothes from the rail. When I walk back through a few hours later, more clothes hang in their place.

Students are rarely noticeable in and around this area of the hospital, but it is with and through these patients, more than 7,000 passing through each day, that India's most esteemed young doctors are formed.

I walk on, past the paediatric OPD on my left, whose queue has subsided by this time of the morning (those who didn't get appointments will try again tomorrow), and then past the generic drugs pharmacy, whose queue will only

disperse when the shutters are lowered in a few hours' time. A car honks impatiently as it negotiates its way among people and stray wheelchairs. I am always offended by this aggressive action, by the lack of respect for the pain-ridden bodies that populate the pavement and curbs. But today I wonder if this incursion is any more offensive than the price of parking a car at an NHS hospital in Britain. The same assumption seems to be disrupted here – that there is something sacred about this space that sets it apart from society beyond the gates, and that a honking car, or an astronomical parking fee, undermines that understanding. Sandbanks appear above the waterline, belying the idea that AIIMS is an island.

Turning right, I enter the institution's administrative and educational nerve centre. This is the boundary between the clinical and academic worlds of AIIMS – between the hospital and the university. Once inside the building, patients disappear. There might be the occasional family member hovering aimlessly outside the lobby, but groups of patients and families are absent. If they drift off-course during the effort to navigate the hospital labyrinth, they will be policed away from this haven – a large quadrangle laid with a well-irrigated jade green lawn, edged with palm trees and rose beds, and stone curbs painted in warning stripes to discourage sitting. The huddle of buildings seems to cushion sound, which adds to the qualitative difference between the two environments. It is calm here, amidst milling students and faculty members. This is a different place, where precarity is hidden.

As if in testimony to the photogeneity of this side of AIIMS – together with its cachet in the medical world – two male delegates are having their picture taken beside the signs advertising the surgical conference taking place. A table at the lobby entrance holds a display of surgical instruments; a gleaming seduction of passing students, emphasizing the lure of a surgical career.

I skirt the quadrangle and cross the road, avoiding the eyes of the security guards as I pass into the heart of student life. The men's hostels stand on one side of a pedestrian road, and on the other the photocopying and stationery shop, general store, and outdoor café where I conduct my interviews, drinking syrupy coffee and trying not to flinch when the local troupe of monkeys clatters across

the fibre glass parasols that protect the tables. Noticeboards advertise postgraduate coaching classes, proofreading services, and events from last year's Pulse, the annual student festival. Students of all ages mill about, some in their white, or greying, coats, with stethoscopes slung around their necks. These, we are informed by the media and the medical establishment, are examples of India's 'best' – its most gifted, dedicated, promising students. And there are moments, even when I am in the thick of uncovering the many caveats and complications, the privileges and implications that this description disguises, that I find myself looking at these young people as though they are in fact somehow different, special, removed from the norm. What does this mean – for them, for the doctors they will become, for the patients they will or will not treat, for the institution, and for India?

'AIIMS is AIIMS...'

The All India Institute of Medical Sciences (AIIMS) opened its gates on Aurobindo Marg in Delhi's South Extension in 1956. AIIMS is a postcolonial institution embodying the ambition of a newly independent India, with origins in a colonial proposition, informed by global expertise, and realized with the support of international donors (see chapter 3). It is an enormous government-funded hospital, anomalous in the public healthcare landscape for employing many of India's most respected doctors, who consistently provide a high standard of free or low-cost care to patients of low socioeconomic status. It also occupies an unassailable position atop the hierarchy of Indian medical education. In recent years, this position has been formalized by the promotion of an annual ranking of colleges by the news magazine India Today¹; a framed cover of the magazine declares the continued domination of AIIMS from a wall in the office of the Institute's academic dean.

This thesis is an anthropological study of AIIMS, with a primary focus on undergraduate, or MBBS, education. My analysis proceeds from an

¹ <http://indiatoday.intoday.in/bestcolleges/2016/> [accessed 19/08/16].

understanding of the institution as simultaneously insulated from, permeated by, and complicit in the sociomedical landscape beyond its gates. Maintaining this perspective throughout the chapters that follow, I interrogate what is contained within the description of AIIMS and its students as ‘the best’. How is ‘the best’ defined and experienced? How does it inform articulations of aspiration and excellence, at global, national, and individual levels? And what implications might the ways in which India’s ‘best’ young doctors are produced contain for the politics and practice of health and medicine?

In the pages below, I introduce AIIMS as a site of anthropological study and explain the necessity of understanding the institution as a symbiotic combination of college and hospital. I situate my work as a response to the lack of anthropological attention to both AIIMS specifically, and to Indian medical education more broadly, and I position it in relation to literatures on hospital ethnography and the training of health professionals, little of which pertains to the Global South. Given my argument that AIIMS is influential in the broader landscape, I conclude the chapter with a contextual sketch of contemporary Indian healthcare and medical education.

*

The primary stated objectives of AIIMS are to set national standards in education, research, and the provision of care to underprivileged citizens; this complex and ambitious mandate makes for an unrelenting challenge. The table below captures the scale for which the institution is famous and hints at the pressure under which it operates.²

² A long-planned expansion was sanctioned in 2016, which will see the creation of an additional 1800 beds across seven departments on a new 15-acre site. See: <http://www.aiims.edu/images/press-release/HFW-AIIMS%20Trauma%20Centre-22%20Feb2016.pdf> [accessed 29/08/16].

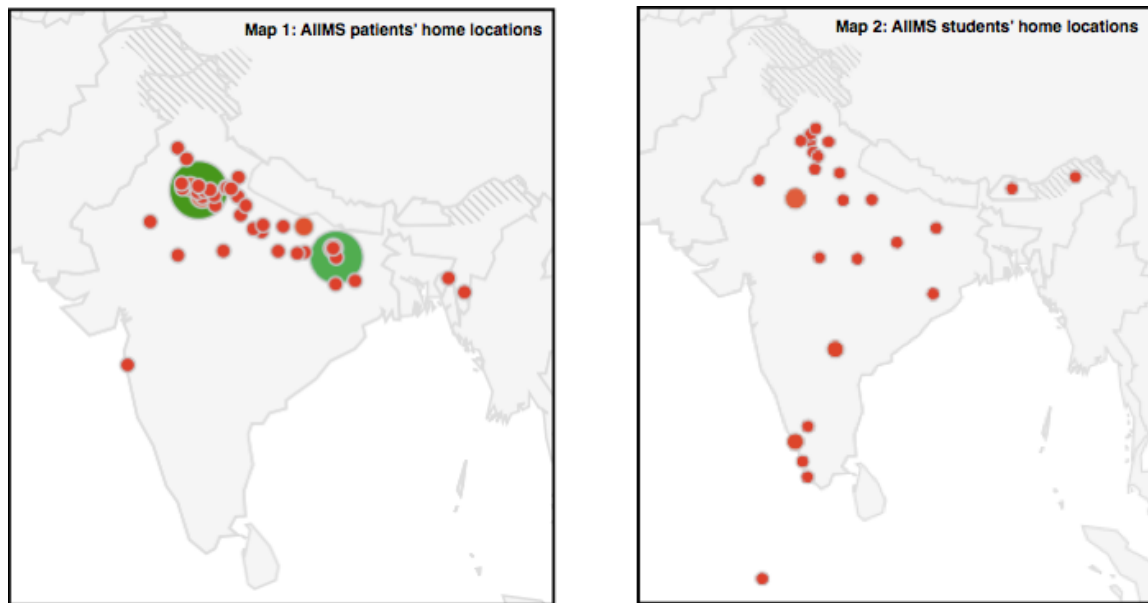
AIIMS Snapshot 2013–14	
Faculty Members: 492	Departments and Centres: 52
Non-faculty Staff: 9378	2.7 million outpatients (~7400/day)
MBBS Students: 379 (2717 MBBS graduates since 1961)	200,000 admissions
Nursing/Paramedical Students: 307/78	150,000 surgical procedures
Clinical Postgraduates: 962	Annual Budget: INR 1,700 crores (~£17 million)

Table 1. AIIMS Annual Report 2013-14: <http://www.aiims.edu/aiims/annual-report/AIIMS%20Report%20English%202013-14.pdf> [accessed 19/05/16]

By way of comparison, in his study of AIIMS, T.N. Madan cites the following figures for the year 1974–75: 450,291 outpatients, 19,782 admissions, and 33,949 surgical procedures (1980: 45).

The majority of AIIMS patients are from North India, with a minority travelling from further afield for specialist treatment. As reflected in the map below, almost all of the 78 patients and/or family members I spoke with at the hospital were from in and around Delhi, Bihar, and Uttar Pradesh (UP). Both Bihar and UP suffer from some of India's most inadequate public healthcare infrastructure (see below), and patients from these states often make arduous and financially draining journeys to AIIMS in search of competent treatment. Having arrived by train, patients, usually with at least one family member, must then join the queue that forms outside the AIIMS main outpatient department (OPD) from 3am each morning; if they are fortunate they will have their *parcha* (patient card) made that day and be directed to the relevant department. Many patients, however, will not reach the front of the queue before the OPD registration closes for the day, and they will have no choice but to wait and queue again the following morning.³

³ Temporality is one of the many dimensions of the AIIMS experience that I am unable to explore in depth here. Future work could fruitfully employ a temporal lens to explore the divergent experiences of doctors, who must cope with a perpetual time deficit in which to manage all that is expected of them, and patients, who are forced to accept a surfeit of time until they are seen. For examples from this rich seam of research see Auyero (2012) on the 'tempogeography' of waiting for public services in Argentina, Holston (2008) on waiting as an expression of citizenship, and Jeffrey (2010) on 'timepass' among educated unemployed North Indian men.



The origins of AIIMS students and trainees, however, present a more pan-Indian face of the institution, as reflected in the map above. This regional diversity has consequences for social dynamics among students, as I explain in chapter 5.

Virtually everyone has an opinion about AIIMS, especially if they are from Delhi. It is a phenomenon as much as a collection of concrete buildings. Impressions might be formed during years of driving within sight of the modernist complex, whose neon sign alerts the city to its presence. Or, while stuck in traffic outside the hospital gates, where patients and families sleep on the pavement for want of anywhere else. Or, via the media, which fuels public perceptions of the institution, for both better and worse. As an illustration of its media presence, in August 2016, a Google search for news stories related to AIIMS produced 158,000 results, while the same search for Safdarjung Hospital – an older government institution directly opposite AIIMS – returned 8,440 results.

News articles and opinion pieces about AIIMS are often critical, alleging corruption (Rajshekhar 2015; see below), dysfunction (Gupta 2014), and neglect or malpractice (Unnikrishnan 2016). But they also regularly emphasize the position of AIIMS clinicians at the top of India's biomedical hierarchy. Prime Minister Indira Gandhi was taken to AIIMS following the 1984 shooting that

would prove fatal; subsequently, AIIMS has been the hospital of choice for Indian political figures.⁴ Stories underline the unparalleled expertise of AIIMS doctors in performing complex surgery on patients with rare conditions such as unusually large tumours (India Today 2015), or undertaking the separation of conjoined twins (Chandra 2013). During the violence in the Kashmir Valley in the summer of 2016, a team of eye surgeons flew to the state to examine the victims, most of them young, of the pellet guns used by the Indian army to subdue protesting citizens. Penetrating the eyes, the metallic pellets threaten the sight of victims, several of whom were airlifted to AIIMS for surgery (Iqbal 2016). Young victims of horrific crimes, most notably child rape, are also usually treated at AIIMS (Pandey 2013). In the last two years, political wrangling over the specific locations of new branches of AIIMS⁵ has become a regular news feature, increasing the institution's visibility.

The media also reflects and reinforces the reputation of AIIMS as the country's most highly-regarded medical college⁶. Each summer, local and national newspapers fete the successful applicants to the AIIMS undergraduate MBBS programme – 72 of them from the 80–90,000 hopefuls who take the annual entrance exam, with its success rate of less than one tenth of 1% (see chapter 4). Those ranked highest – the 'toppers' – are profiled with their families, and their advice is sought for next year's aspiring applicants (see Bedi 2016; Nanisetti 2016; Mehtal 2016). In chapter 4, I posit the concept of a 'biographical number' as a lens through which to approach the impact of exam ranking on subjectivity. More broadly, taking a cue from the work of Henrietta Moore and Nicholas Long (2013) on the social life of achievement, I suggest in

⁴ In recent months, External Affairs Minister Sushma Swaraj and Water Resources Minister Uma Bharti have both been treated at AIIMS. An AIIMS medical board was involved in the investigation into the poisoning of Sunanda Pushkar, wife of MP Shashi Tharoor, which garnered a huge amount of media attention. And in October 2016, a team of specialists from AIIMS flew to Chennai to consult with doctors at the private Apollo Hospital on the treatment of Tamil Nadu Chief Minister J. Jayalaalitha.

⁵ This thesis focuses on AIIMS Delhi, but see chapter 7 for a note on the expansion of the AIIMS network and its future research potential.

⁶ A recent documentary, *Placebo* (2015, dir. Kumar), filmed undercover at AIIMS by the brother of a student, purports to address this question by exploring the pressures of life at the Institute. While it largely fails to offer a broader perspective, it does provide insight into life in the men's hostels.

the following chapters that the fact of winning admission to AIIMS can be understood as an event that influences how students think about themselves, and those around them, both in the present and the future.

Finally, even if AIIMS means little to an individual, from most locations in Delhi it is usually possible to reorient oneself via the ubiquitous road signs pointing the way to the hospital. AIIMS is *there*: embedded in the landscape of Delhi, and in imaginations both within and beyond the city.

Situating the study

Although many of the themes in the thesis are undoubtedly applicable to any Indian medical college, this is very much a story of AIIMS. While I show the ways in which AIIMS is permeated by social norms to an extent that undermines certain perceptions of its exceptionalism, I also argue that it influences the Indian sociomedical scenario in turn. It is this influence, born of the unique status described above, that precludes any analysis of the All India Institute as a decontextualized or interchangeable clinical setting.

AIIMS, therefore, is a character in this story in its own right. Were I predominantly interested in how the institution functions from an organizational perspective I would be concerned to draw on the relevant literature for analytical insight (Bate 1997; Kirkpatrick 1979; Pedersen & Humle 2016; Wright 1994). However, what distinguishes AIIMS among Indian medical colleges is the way in which it operates in both imagination and practice, or as both structure and idea; it is simultaneously an institution in both the bureaucratic and the social sense of the word (Douglas 1986; Parry & Guha 1999), and it is through this dual lens that I seek to illuminate it. To borrow from Sarah Pinto's work on 'ersatz medicine' in rural North India, AIIMS demonstrates 'the fluidity of institutional authority as a site of imagination and practice' (2004: 355). In thinking about AIIMS in this way, I also take inspiration from Akhil Gupta's now-classic approach to the state as demanding analysis of both 'everyday practices' and 'discursive construction' (1995: 375). Itself an institution of the state, AIIMS is similarly produced through these

combined dimensions. I reflect in detail on these dynamics and their consequences in the conclusion to the thesis.

Despite (or perhaps because of) its high public profile, AIIMS has received remarkably little academic attention. Writing about the challenges and rewards of conducting ‘public ethnography’, Didier Fassin notes that while ethnography must pay attention to understudied social locales, it also retains salience in ‘spaces saturated by consensual meanings’ (2013: 642). In the first circumstance, he writes, ethnography ‘illuminates the unknown; in the second, it interrogates the obvious’ (ibid.). When I began this work in 2012, AIIMS struck me as a particularly enticing fieldsite by encompassing both sets of circumstances. It is notably understudied and thus constitutes a ‘black hole of ethnography’ in Fassin’s terminology (ibid.: 629), and yet as a nationally renowned institution uniquely embedded in the imaginations of diverse Indian publics, it is also a repository of unchallenged assumptions.

T.N. Madan’s (1980) survey of doctors at AIIMS in the 1970s remains the only substantial enquiry into the institution from a social science perspective.⁷ His study is based on questionnaires completed by AIIMS doctors, interviews, and on secondary sources for piecing together the institution’s history (for which I am very grateful – see chapter 3). While Madan’s work is neither ethnographic, nor focused on students at AIIMS, it remains an invaluable reference point for how attitudes and orientations within the Institute have changed or endured since the 1970s, and I make use of his data throughout the thesis.

Rama Baru (2010) has written about retired AIIMS doctors and their views of the private sector, and argues for a more nuanced understanding of the processes that have led to the alienation of both patients *and* clinicians from public healthcare in India. These processes, she suggests, are associated with the changing composition of the Indian middle class, and the economic structures in which they are embedded. Reflecting the narrative of ‘the Fall’ of the Indian middle classes from the post-independence Nehruvian era of a frugal lifestyle of

⁷ Among graduate student colleagues I know of two people whose work includes AIIMS as one site among others in studies of post-mortem politics, and the development of medical specialities, but this case study approach is more concerned with comparative specificities than the ethos of the institution as a whole.

national service, to the contemporary post-liberalization predicament of selfish consumerism⁸, Baru's informants describe a change in the Indian medical profession as opportunities to earn large salaries in the private sector increased. The doctors who spent entire careers at AIIMS speak of being motivated not by money but by the opportunity to be part of 'the premier institute of the country' wherein one could 'see medicine in its full spectrum' (89-90). One informant is explicit that he was 'motivated by the desire to gain name and fame' (90), which AIIMS enabled him to do, while another explains that, 'in the early phase the "self" was subordinated to the institution but later the self took over' (91). The tussle between these competing instincts remains relevant in the decision-making of today's AIIMSonians, as I explore in chapter 7.

In work on treatment-seeking, AIIMS arises periodically as a feature in the healthcare landscape, often to emphasize the uneven scale and quality of provision (Das 2015, for example). Historians of medicine and public health occasionally mention the establishment of AIIMS if their focus extends beyond 1947 (Jeffrey 1988), while C.G. Pandit's (1982) memoir of his involvement with the early planning for AIIMS is crucial to the story of the Institute's foundation that I tell in chapter 3.

I have encountered no other academic work that seeks to understand the contemporary life of AIIMS as a medical college, the experiences of its students, or its wider influence. My thesis is, to my knowledge, the first ethnographic study of the All India Institute, and, I believe, of Indian medical education and doctors-in-formation.

Why might this be? I would venture that social scientists with an interest in Indian health and medicine have largely ignored AIIMS for two reasons: firstly, the challenge of gaining research access to large public institutions is formidable and demands a quantity of time that not all researchers can afford; secondly, those with an eye to health inequalities and social (in)justice are more inclined towards community-based studies that provide insight into the local ecosystems of illness and treatment-seeking among often marginalized groups

⁸ See Varma (2007) for a classic version of this narrative, and Cohen (1998) for examples of how it is employed with regard to the perceived disintegration of traditional family structures.

(for exemplars of this kind of work see Das 2015; Pinto 2008; Van Hollen 2003). In these contexts, AIIMS is a remote and exceptional site, usually only mentioned as an outlier in the landscape of Indian public healthcare. My thesis seeks to add nuance to this perception, by suggesting that AIIMS influences the broader landscape in both imagination and practice and therefore, by extension, the experiences of patients who may never personally attend the Institute. In considering this wider influence, I hope to implicitly make a case for the validity and import of studying institutions that appear at first glance to be unrepresentative of the broader landscape in which they sit.

It is a polyvalent understanding of the institution that I also suggest challenges any perceived limitations of an ostensibly single-sited ethnography. Reflecting on his choice to conduct a village study in the original tradition of anthropology, Brighupati Singh (2015b) asks whether, bucking the trend towards “multi-sited” ethnography or transnational movement, as the way to engage the kinesis of this world⁹, it might be possible ‘to travel, to become planetary, while staying in one place,’ such that stillness ‘also enables a movement between different dimensions, or thresholds of life,’ or, whether being in one place may also allow one to be multi-sited. This is not in fact dramatically different from what George Marcus (1995, 1999) intended through his original conception of ‘multi-sited ethnography’. In focusing on the ways in which ideas and norms flow in and out of AIIMS, influencing perceptions within and without the institution, I hope to achieve a similar effect with this thesis.

Dr E’s question, with which I opened this introduction, about whether AIIMS is a medical college with a hospital attached or vice versa, has proved central to my thinking. This is partly for what it reveals about the life of AIIMS, but also for the methodological implications of the symbiotic relationship between the two dimensions of the institution. While my primary focus is on students at AIIMS, their experiences are greatly informed by the life and the idea of the hospital, its

⁹ Citations from: <http://somasphere.net/forumpost/reply-to-comments> [accessed 27/08/2016].

faculty, patients, and practices. Consequently, in the following sections I explain how the thesis is situated in relation to, and attempts to bridge a gap between, two bodies of relevant literature, resulting in what I hope might be a novel contribution to the medical anthropology of India.

A hospital with a college attached...

Hospitals offer rich terrain for anthropological research, dense with meaning and experience for a variety of actors. And yet, as Alice Street notes in the introduction to her ethnography of Madang Hospital in Papua New Guinea, ‘...hospitals remain somewhat neglected sites for the study of colonial, postcolonial, and development relations in the social sciences...historical accounts of the emergence of the modern hospital remain extraordinarily Eurocentric’ (2014: 19). Hospitals, she goes on,

...need to be explored ethnographically as historical as well as spatial infrastructures. As spaces of ongoing state building and monuments of modernity and progress, their material form carries the traces of past interventions, ideologies of race and development, and shifting biomedical terrains into the present (21).

Western medical sociology of the 1950s and 1960s represented hospitals as compact functioning units removed from wider society – the hospital as ‘a tight little island’ (Coser 1962; see also Baziak & Denton 1965; King 1962). In her work on the gynaecological ward of a hospital in Punjab in the 1960s, Joanna Kirkpatrick (1979) criticizes this view as ethnocentric. She argues that the close involvement of in-patients’ kin made the Indian hospital appear less isolated than in Western studies. The contemporary perspective has developed further to approach all hospitals as very much part of the social mainland (Long et al. 2008; Street & Coleman 2012; van der Geest & Finkler 2004).

This assertion, that ‘a hospital is not an isolated subculture, but rather...is a microcosm of the larger culture of which it is a part,’ as Shahaduz Zaman (2004: 2026) writes of the government teaching hospital he studied in Bangladesh, sounds commonsensical. Street and Coleman, however, urge

caution against dismissing the aspects of hospital life that may be unique to its particular institutional status, that is, the evidence of a hospital's capacity 'to be *simultaneously bounded and permeable*' (2012: 4, my emphasis). Central to their discussion is an exploration of the hospital as something between a disciplinary, panoptic institution (Foucault 1994) and a mirror image of society. To this end they cite Hetherington's (1997) extended definition of Foucauldian heterotopias as 'spaces where different kinds of social ordering, which can be either transgressive or hegemonic, are tried out', as a means through which to explore hospitals as unique worlds simultaneously imbricated in broader social orderings (Street & Coleman 2012: 9). Many of the students in this thesis speak quite precisely to a unique social and educational ordering as definitive of their AIIMS experience (see chapter 4). While I interpret this predominantly through a lens of liminality (Turner 1967; Horvath et al. 2015), future work might productively consider the theoretical relationship between ideas of the liminal and the heterotopic.

Understanding AIIMS as both insulated and permeable exposes the dialectical nature of these two states and allows me to write both about the ways in which AIIMS purports to be (and is) unique, and the ways in which the life of the institution belies its claims to exceptionalism. Further, interrogating the influence of these dynamics on the development and aspirations of young doctors leads me to posit an addition to Street and Coleman's formulation, namely that there are ways in which AIIMS can also be considered – as an outcome of this insulated/permeated dialectic – *complicit* in the sociomedical landscape beyond its gates.

*

Foucault's 'archaeology of medical perception' described in *The Birth of the Clinic* (1994) is often read in two, not unrelated, ways. The first is concerned with the development of the clinical gaze in eighteenth-century France, and is often distilled to the epistemic break that Foucault explains as a shift in clinical questioning from 'what is the matter with you?' to 'where does it hurt?' The

second is the development of the hospital itself as a site of surveillance and governmentality, as the responsibility for public health was shifted from the domestic to the clinical sphere. I touch on the former dimension in my discussion of how medicine and doctoring is communicated to students and patients at AIIMS in chapter 6. It is the latter aspect, however, that speaks more directly to my analysis of the institution and the implications of medical students' experiences. On this front, there are three interventions that I find particularly useful qualifications of Foucault's formulation in relation to AIIMS.

Firstly, Diana Gibson (2004) describes how, based on her work in South African hospital settings, resource constraints produce 'gaps in the gaze' through which patients are often rendered invisible to medical and state surveillance. Alice Street pursues this thread, arguing that Madang Hospital in Papua New Guinea is a site in which patients attempt to *make themselves seen* by the state, being more accustomed to falling through the gaps in its gaze:

In a place where people predominantly imagine themselves to be invisible (to the state, to doctors, to a global scientific community) the hospital becomes an intense site of visibility work where bureaucratic and biomedical technologies are engaged with as relational technologies that can make the person visible in recognizable and affectively persuasive forms. (Street 2014: 13–14)

This idea of 'visibility work' taking place in the hospital is particularly pertinent to the large number of patients who travel long distances to seek treatment and care at AIIMS. In chapter 6, I introduce the concept of 'patient labour' to explore how student doctors benefit from this visibility work by patients compelled to seek treatment at AIIMS given the dearth of reliable infrastructure beyond the city. For my argument that AIIMS is *complicit* in the sociomedical landscape beyond its gates, however, Kalpana Ram's intervention based on her ethnographic work in South Indian clinics is crucial:

We have inherited, from the work of Foucault, a powerful model with which to understand the way in which modern rationalizing endeavours such as clinical medicine work as modes of power by creating a specifically circumscribed *site*. On the inhabitants of this site, exercises

of observation and enumeration, and precise forms of intervention, can be methodically undertaken. But the model does not adequately convey the extent to which power relies, too, on overlap, on a certain leakiness of both temporal and spatial boundaries. (Ram 2010: 209-210, original emphasis)

Ram prefers Bourdieu's (1990) concept of habitus as a means of understanding power dynamics within the clinic, based on 'the ways in which the past flows through individuals, absorbed as a part of their repertoire with which they meet the challenges of the present, without necessarily being aware of every element' (Ram 2010: 204; and see chapter 6).¹⁰ This orientation also helps us to approach the ways in which certain perspectives are embodied by students on arrival, informed by years of preparation for the AIIMS entrance exam, and by virtue of being citizens of the society in which the institution sits.

Corruption talk

The autonomy of AIIMS is guaranteed in principle by the Act of Parliament that confirmed its foundation in 1956; the associated government funding ensures it is adequately equipped, staffed, and maintained. It is further protected by its autonomy from the Medical Council of India's (MCI)¹¹ oversight of both medical curricula and institutional administration. In practice, founded according to the vision and ambition of both pre- and postcolonial administrations (see chapter 3), AIIMS has always been a political institution that has periodically suffered from and sometimes colluded with direct interference in its functioning. A retired faculty member told me that direct interference in the functioning of the Institute only became routine in the 1980s, when AIIMS became the hospital of choice for politicians, following the assassination of Indira Gandhi. In Madan's study conducted in the 1970s, however, he cites an informant telling

¹⁰ Considering the 'leakiness of both temporal and spatial boundaries' (Ram 2010: 210) also speaks to the point I raised above about the deceptively rich potential of a single-sited study.

¹¹ At the time of writing, under direction of the Supreme Court, a three-judge panel has been charged with overseeing the MCI based on longstanding allegations of misconduct. In July 2016, it was reported that a government committee would propose replacing the MCI with a new National Medical Commission (Economic Times 2016).

him that ‘the long arm of the government is very visible in the manner in which the Institute is run’ (1980: 90). The central government minister of health and family welfare is also president and chairman of AIIMS, while members of Parliament and civil servants comprise half of the eighteen-member Institute Body and just under half of the Governing Body.¹²

In recent years, there have been two particularly visible instances of political interference in the administration of AIIMS. Following the agitation in 2006 against increased quotas of reserved places for students and faculty from Other Backward Classes (OBCs), headquartered at AIIMS with the alleged support of the director (Venkatesan 2010; see chapter 4), the Congress government’s health minister was accused of persistent interference, culminating in the removal of the director (Rashid 2015). More recently, civil servant Sanjiv Chaturvedi was removed from the post of chief vigilance officer at AIIMS following his investigations into 165 cases of alleged corruption over two-and-a-half years – a move widely alleged to be a politically motivated calculation to protect the interests of senior figures in government and the AIIMS administration implicated in Chaturvedi’s work (Business Standard 2015; Sethi 2014).

‘Corruption’, Haller and Shore contend, ‘represents both an ethnographic enigma and a “social fact” in the classical Durkheimian sense’ (2005: 6). In their call for an anthropology of corruption, they echo the challenge of other scholars to standard institutional definitions, such as that by the World Bank, of corruption as the ‘abuse of public office for private gain’ (2), and encourage its understanding as ‘something more subtle, layered and complex...a form of exchange: a polysemous and multi-stranded relationship and part of the way in which individuals connect with the state’ (7; Gupta 1995; Visvanathan and Sethi 1998). ‘Corruption talk’ (Haller & Shore 2005: 6) is ubiquitous in and around AIIMS; it ranges from the *jaan-pechaan*, or personal connection, that some patients utilize to access treatment, to suspicions of kickbacks from off-campus pathology laboratories, discriminatory treatment of students and faculty in

¹² For the complete AIIMS administrative structure see: <http://www.aiims.edu/en/about-us/administration.html> [accessed 29/08/16]

reserved categories, and the allegations of systemic malpractice noted above. In the chapters that follow, I do not attempt to analyze corruption as a distinct entity, or to interrogate the truth or falsity of allegations – to do so would be to misrepresent it as a discrete practice, while also presenting significant methodological challenges that would have led to a different sort of thesis (ibid.: 13–16). Rather, where corruption talk arises, I treat it as another example of how AIIMS is embedded in and reflective of broader Indian society.

Resources

Recent years have seen the publication of several exemplary ethnographies of hospitals in the Global South. Monographs by Alice Street (2014), Julie Livingston (2012), Claire Wendland (2010), and Shahaduz Zaman (2005) about hospitals in Papua New Guinea, Botswana, Malawi, and Bangladesh, respectively, build on and enrich a subfield that has been encouraged and supported by anthropologists such as Sjaak van der Geest and Kaja Finkler (2004). Their co-edited special issue of *Social Science & Medicine* showcases an array of ethnographic case studies that ‘open, as it were, a window to the society and culture in which the hospital is situated,’ (ibid.: 1998), whether that be in South Africa (Gibson 2004), Ghana (Andersen 2004), Mexico (Finkler 2004), or Papua New Guinea (van Amstel & van der Geest 2004). There are clear parallels between my work and much of this literature – most obviously, the postcolonial nature of many of the institutions and their role as public hospitals catering to large numbers of poor patients, many of whom suffer multiple deprivations as marginalized citizens of developmental states.

Our paths diverge, however, upon reacquaintance with the reputation of AIIMS as the home of many of India’s most highly-regarded clinicians, and, by extension, at the question of resources. The monographs noted above, together with the articles by Gibson (2004) on South Africa, and Andersen (2004) on Ghana, all share a concern with the ways in which resource scarcity in hospitals reveals the instabilities and contingencies of ‘biomedicine’ in different terrains, demanding improvisation and bricolage on the part of both medical

professionals and patients in order to achieve some form of therapeutic outcome in straitened circumstances.

Patients and doctors at AIIMS suffer more greatly from the consequences of limited time and space than from an explicit lack of institutional resources, pressured though these are. There may be temporary shortfalls in certain supplies, or a delay in procuring new equipment given the bureaucratic procedures involved, but unlike many public hospitals in the Global South, AIIMS is not defined by chronic shortages and the constant struggle to compensate described so strikingly by Livingstone (2012), Wendland (2010) and Street (2014). If anything, the pressure on resources at AIIMS illuminates how profoundly they are lacking beyond its gates, as patients crowd into the OPD to seek the care they cannot access elsewhere. I do not, however, want to overdraw the distinction by conjuring an image of AIIMS as a salubrious environment. It is not: it is dilapidated in places, paint cracks and peels, ceiling panels deteriorate and are occasionally missing; air conditioning exists in some spaces and not others; when charities dispense free food to the waiting crowd, they leave behind mounds of soiled paper plates spilling from the pavement onto the road; there are too few seats, there are far too few toilets, and faculty recently called for a stay on recruitment until new doctors' accommodation is built (Business Standard 2016). AIIMS is not, in any sense, an aesthetically therapeutic environment for either doctors or patients – it is crowded, confusing, uncomfortable, not always clean. It has little in common with India's corporate hospitals designed to imply therapeutic concern via an aesthetic akin to a five-star hotel (Lefebvre 2008).¹³ It often seems to speak less of an effort to impart health than a perpetual scramble to stave off decay.¹⁴

Nevertheless, its resources have always set AIIMS deliberately apart from others in the Indian public healthcare landscape. AIIMS is an undeniably unique institution – it resists easy inclusion into a compendium of resource-constrained

¹³ Also see Gesler (1992) on therapeutic landscapes, and Street (2012) on 'affective infrastructure'.

¹⁴ When I last visited AIIMS, in March 2016, a modernization programme contracted to Tata Consultancy Services had begun to manifest through a new waiting area and updated signage, as well as the early stages of a digital appointment system.

medical institutions of the Global South, but it is clearly not of a piece with public hospitals in the Global North either. This is not because of a lack of technical capacity, but rather because of its identity as the country's pre-eminent training institution that simultaneously caters to vast numbers of underprivileged patients. In chapters 6 and 7, I argue that this dynamic has implications for how it produces new doctors and how we understand its role in the broader landscape of Indian healthcare.

...And a college with a hospital attached

Differentiated from their peers at the moment of admission, AIIMS students are catapulted into an exclusive club whose membership is aspired to by many but achieved by a tiny minority of applicants. The numbers invoked by students vary, reflecting the slightly mythical quality that attaches to the ferocious level of competition for seats. Among the students with whom I interacted during my fieldwork, the number of competitors was variously cited as between 50,000–200,000. The AIIMS annual reports for 2012 and 2013 claim that of 76,014 applicants, 58,002 sat the exam in each year; the identical numbers cast doubt on their validity (and they are lower than popularly understood), but they give us a general impression. By 2015 the number had risen to 300,000 candidates competing for 672 seats spread across the six AIIMS of North India.

Five new branches of AIIMS were established in 2012; they are currently considered much less prestigious than AIIMS Delhi. The allocation of seats at the various branches according to a student's rank reflects an emerging hierarchy of preference (with Delhi in its own league at the top), but this had not yet entered the discourse of the students I spoke with. It was raised in my conversations with students attending Pulse from AIIMS Bhopal, however, who readily acknowledged its shortcomings in comparison with the Delhi original. This suggests the value of studying the new branches in future, as they develop identities both independent of and in relation to AIIMS Delhi (see Jha 2014).

The members of the Delhi graduating batch of 2016 will join an AIIMSonians network that has accumulated no more than 2,900 members since

the first cohort graduated in 1960. In 2008, following a government policy to increase the number of seats reserved for students from disadvantaged groups, the number of annual MBBS seats at AIIMS was increased from 50 to 72. In September 2016, AIIMS Delhi announced that from 2017 it would increase its annual MBBS intake to 100 students. At present, the 72 existing seats are divided into four categories, three of which comprise reserved seats: five for Scheduled Tribes, 11 for Scheduled Castes, and 19 for Other Backward Classes, the addition of which provoked a mass agitation by members of the medical fraternity in 2006 (see chapter 4). The remaining 37 seats compose the so-called General Category, which is ostensibly open to all, but is dominated by members of upper castes.

AIIMS is the greatest repository of social and cultural capital (Bourdieu 1986) in the landscape of Indian medical education – a convertible capital that students take with them on graduation, and an amount of which, I argue in chapter 4, is also a pre-requisite for admission. One of the more tangible features that differentiates AIIMS from other colleges is the confidence it bestows upon its graduates – a relatively greater sense of security about the future than that available to students of less prestigious institutions. This privilege, however, also contains pressures about what is expected of an AIIMS graduate, which some students have to confront and negotiate (Long & Moore 2013; see chapter 7).

*

Analysis of the ways in which medicine operates as a sociocultural system that reproduces rather than remedies inequality and injustice has long been a mainstay of social science, and medical anthropology in particular (Farmer 1999; Illich 1982; Lock & Gordon 1988; Navarro 1976; Scheper-Hughes & Lock 1986; Baer et al. 2013; Taussig 1980). While the training and practice of health professionals is often the means through which such reproduction occurs, Adams and Kaufman note that ‘seldom has analytic focus been explicitly on the health professionals themselves’ (2011: 314). Within the work that does exist, there have been two broad phases. Work that focused on how students are

socialized to become professional doctors – how they acquire ‘a physician identity and character’ (Hafferty & Franks 1994: 865; see also Becker et al. 1961; Conrad 1988) has in recent years been complemented by research that enquires into the ways in which student subjectivities evolve during processes of clinical training. As Holmes, Jenks and Stonington (2011) put it in their co-edited special issue of *Culture, Medicine & Psychiatry*:

...clinical trainees are not simply socialized and malleable, but are also active subjects who make choices, resist subjugation, accommodate power differentials, and use techniques to actively craft themselves internally throughout the process of becoming a new kind of professional. (109)

Vincanne Adams and Sharon Kaufman (2011) suggest that the long-term work of Renee Fox (1957, 1980, 2000) on how medical uncertainty is inculcated during clinical training is an important bridge between these two approaches, drawing ‘connections among medical training, practice and the formation of “medical citizenship”’ (Adams & Kaufman 2011: 315) that the historian of medicine Charles Rosenberg (2007) advocates for in contemporary American practice. This latter detail is an important clue to the overwhelming focus on clinical training in the Global North, even in the more recent literature. In the *Culture, Medicine & Psychiatry* special issue, all but two of the ethnographic articles draw on research with trainee clinicians in the US, and of the two exceptions, one (Brada 2011) is concerned with how American medical students’ experiences of a public hospital in Botswana contribute to framings of ‘global health’.¹⁵

In focusing on doctors-in-information at AIIMS, I speak to a surprisingly small anthropological literature on the training and socialization of medical professionals in the Global South. Claire Wendland’s (2010) work on medical education at Queen Elizabeth Central Hospital in southern Malawi is a key recent contribution that argues for more attention to the material contexts of medical training in the Global South. I use Wendland’s work as both

¹⁵ The other is Stonington’s (2011) article about changing conceptions of death and end of life care in Thailand.

complement and counterpoint in this thesis, particularly in chapter 7, where I discuss students' relationships with the state, and the types of medical citizens they may go on to become.

There exists a longstanding interest among social scientists in the *practices* of Indian medical professionals, exemplified by the early work of T.N. Madan (1972, 1980). This includes attention to 'subaltern therapeutics' (Hardiman & Mukharji 2012) and practitioners of indigenous medical techniques (Lambert 2012); particular biomedical specialists such as gastroenterologists (Ecks 2010); community health workers and health visitors (Sheikh & George 2010; Kielmann et al. 2014); and of course the enquiries noted above into the work and opinions of doctors at AIIMS (Madan 1980; Baru 2010). The processes through which these practitioners are formed, and the implications of those processes, however, have received little attention. Vandana Dandekar's (2013) study of reservations at a government medical college in Maharashtra is a notable exception for its interest in medical students. While the specific contexts of studies in the Global North may not be applicable to my work, some of the questions this body of work raises certainly are. In particular, two questions posed by Holmes et al. (2011) have been suspended in my thoughts as I have written this thesis:

What kinds of people are formed through contemporary processes of clinical training, and how do these evolving subjects transform health, power, and other aspects of social life? ...how are trainees pushing back or dialectically crafting the field that is simultaneously crafting them?' (Holmes et al. 2011: 106).

In the chapters that follow, I offer some potential answers to these questions, with reference to student experiences at AIIMS. In doing so, I aim to bridge the literatures on hospital ethnography and medical education, and to contribute to the latter in particular from an Indian perspective as I explore how notions of excellence and achievement, and the dynamics of class, reservations, and the politics of health influence how AIIMS students become doctors and the kinds (if any) of medicine they aspire to practise.

Finally, while this is primarily a work of medical anthropology, in the course of my analysis I necessarily draw on a variety of additional literatures that do not have an immediately obvious direct relevance to health and medicine. Work on the history and anthropology of Indian education systems is perhaps the least unexpected of these. Other diverse sources that I draw on include work on the anthropology of numbers (Appadurai 1993; Guyer et al. 2009; Stafford 2010); the politics of reservations and the discourse of merit (Deshpande 2006, 2013; Subramanian 2015); the social life of achievement (Bayly 2013; Long & Moore 2013); and anthropological understandings of value (Graeber 2001, 2013; Otto & Willerslev 2013).

In light of this, there will be moments when the medical dimension of the discussion may seem to slip from view altogether. Throughout the thesis, however, my perspective remains one of an anthropologist attempting to understand the implications of students' experiences at a prestigious medical college for the doctors they may become and the landscape in which they will practise. Alice Street notes that, 'hospital ethnography...enables us to explore the complex institutional life of a simultaneously *biomedical and nonbiomedical*, contained and permeable, place' (2014: 18, my emphasis). The same holds true for AIIMS as a medical college. While certain themes have transferable implications, I deploy them here with an eye to the ways in which they inform the evolution of new doctors – specifically those regarded as the country's most promising. In other words, it matters that these students are studying medicine. Taking inspiration from the existing concept (Marmot & Wilkinson 2006), this might be characterized in public health language as a social determinants approach to the study of medical education.

Medicine beyond the gates

As I have described above, my analysis of how excellence is understood and reproduced at AIIMS is informed by the various ways in which the institution relates to the wider sociomedical landscape. I therefore conclude my introduction to the thesis with a contextual sketch of that landscape. I begin with the public and

private provision of medical care and end with a survey of medical education and its intrinsic politics.

As budgets are cut and recent national policies suggest that public-private partnerships (PPPs) and insurance models¹⁶ are set to become the norm in healthcare provision, it is arguably more accurate to describe state responsibility for healthcare provision as an anomalous chapter in India's history, rather than the norm (see Qadeer et al. 2001). Public healthcare has never been a political priority in postcolonial India, nor was it given sustained attention by the British colonial administration (Arnold 1993; Harrison 1994; Bala 2007; see chapter 3). Sunil Amrith suggests that 'the fractured and halting process through which health came firmly within the realm of the state reflected many of the weaknesses of colonial approaches to public health' (2006: 16), and stresses the financial and administrative constraints on the newly independent Indian government (81). Bajpai and Saraya make a similar argument, describing the continuance of a 'colonial governance paradigm' (2011: 315).

These arguments are persuasive – the lack of rural health infrastructure in particular was a major obstacle to the dissemination of equitable public health in the post-independence years, and continues to have visible consequences in the large crowds of patients who travel to AIIMS from across North India. That the colonial legacy of weak infrastructure impeded the *enactment* of post-independence health policy is clear. What it doesn't explain is why the *idea* of state healthcare has never been a political priority,¹⁷ why it has been consistently under-resourced even in times of high economic growth, and what the consequences of

¹⁶ See Patel et al. (2015: 2429) on the proliferation of government-sponsored insurance schemes, which, by 2010, covered close to 25% of the population at varying levels. Despite increased access to healthcare for the poor, however, evidence suggests a limited impact on financial risk protection 'because of relatively low coverage limits and exclusion of expenditure on drugs, outpatient visits, and investigations, which account for a large part of healthcare expenditure' (ibid.).

¹⁷ With the notable exceptions of Tamil Nadu and Kerala, whose successes in state healthcare provision stand in stark comparison to North India in particular, demonstrating the challenge of tackling a subject that is devolved within a federal system. In Tamil Nadu 80% of children are fully immunized, against an Indian average of 43.5%, and Kerala and Tamil Nadu have infant mortality rates of 12 and 22 per 1000 respectively, against an Indian average of 44. These successes are widely lauded, but explanations are in shorter supply. Suggestions include a history of political activism around social issues in the south. (Dreze & Sen 2013: 168-177).

this legacy are for contemporary relationships between citizens and the state that are mediated through illness and medicine.¹⁸

Sunil Amrith (2006: 80) notes the virtual absence of serious discussions of healthcare from the Constituent Assembly debates that took place between 1946–50 among the architects of newly independent India. Where ‘health’ is mentioned, it is most frequently in association with ‘the health of the body politic’ or healthy versus unhealthy national sentiment (also see Mehta 2007). In the final draft of the Constitution, health is subordinated to the Directive Principles, where it forms part of ‘the programme of social transformation...to be realized in the fullness of time’ (Jayal 1994: 22), as opposed to being articulated alongside Article 21, which dictates the right to life.¹⁹ In their review of persistently low government spending on public healthcare, Patel et al. argue that, ‘at the heart of these constraints is the apparent unwillingness on the part of the state to prioritise health as a fundamental public good, central to India’s developmental aspirations, on par with education’ (2015: 2431).

Dreze and Sen (2013: 143–148), and Pratap Bhanu Mehta (2003: 135–160) bemoan the lack of public deliberation of policy issues around essential human services such as health and education, with the result that they are perceived as largely inconsequential for electoral politics (beyond high-profile programmes). As Mehta notes, this cannot be attributed to an idea that those most in need of these services from the state do not vote, because India’s poor *do* vote, and in famously large numbers (ibid.: 135; Banerjee 2014). It does appear true, however, that voters do not generally mobilise around education or healthcare concerns, nor do politicians see sufficient short-term gain in campaigning around health (Saez & Sinha 2010). In her work on the new Indian middle classes, Leela Fernandes (2006) shows how people opt for individualized private strategies of compensating for inadequate public services, rather than mounting political objections (see below).

¹⁸ See Petryna (2002) for her original conception of biological citizenship in the wake of the Chernobyl disaster in post-Soviet Ukraine, and Rose and Novas (2005), and Rose (2006) for subsequent applications. Concepts of various forms of citizenship related to the body and illness have proliferated in recent years – these include, for example, therapeutic (Nguyen 2005), genetic (Heath, Rapp & Taussig 2004), and pharmaceutical (Ecks 2006).

¹⁹ See Khosla (2012) for a discussion of how campaigners for a right to health articulate this as a dimension of Article 21. Also see Jayal (2013).

Mehta suggests a partial explanation for this lies in the fact that the Indian state has rarely 'been governed by a public philosophy; it is rather a high stakes or competitive game in which individuals or groups seek advantages on particularistic lines' (2003: 120). He also claims that 'the two sustaining associations of the state' – with the 'public' or the 'common' – have worn very thin in India (ibid.). From the specific perspective of healthcare, however, we have to ask how effective these associations have *ever* been.

Illness and infrastructure

Home to 17.5% of the world's population, India shouldered 20% of the global burden of disease in 2013.²⁰ Of the world's neonatal and child (under five years) deaths, India accounts for 27% and 21% respectively.²¹ India's communicable disease burden is dominated by tuberculosis, lower respiratory infections, diarrhoeal diseases, malaria, and typhoid. Non-communicable diseases contribute to 52% of India's total disease burden and more than 60% of deaths.²² At the same time, however, in the last ten years life expectancy has risen, infant and maternal mortality rates have fallen, and the WHO has declared India free of polio and maternal and neonatal tetanus.

These statistical narratives are complicated by the health disparities produced by differences in socioeconomic status and class, caste, gender, and geographic location. For example, the under-five mortality rate for children born into Scheduled Tribe communities is 15% higher than the national average. Infant mortality rates between rural and urban areas differ by 17 percentage points, and while 5% of children born to parents in the top wealth quintile are malnourished, that increases to 25% at the opposite end of the scale. When it comes to gender, a 2011 study found that the risk of dying between 1–5 years was 75% higher for girls

²⁰ All data in these paragraphs is taken from Patel et al. (2015).

²¹ Of India's child deaths, 68% are caused by diarrhoea, pneumonia, preterm birth complications, birth asphyxia, and neonatal sepsis. Stunting, a manifestation of chronic nutrition deficiency, has been calculated to affect 38.7% of children under five, and in 2013–14, 29.4% of children were underweight. More than 6% of women are severely undernourished (Patel et al. 2015).

²² The leading causes include ischaemic heart disease, chronic obstructive pulmonary disease, depression, haemorrhagic stroke, and diabetes (Patel et al. 2015).

than for boys. Illustrating regional disparities, a girl born in Chhattisgarh or Madhya Pradesh is five times more likely to die in the first year of life than a girl born in Kerala.

The social determinants of health beyond medical infrastructure are key to understanding these disparities. In their Lancet study, Patel et al. (2015) cite ‘urbanisation, poor access to water and sanitation, food insecurity and unhealthy diets, environmental degradation, social stratification (exemplified by caste), and rising levels of income inequality’ along with ‘income, education, occupation, social status, sex, and ability to participate in social networks’ (2024–2025; also Baru et al. 2010) as the key factors that differentiate one person’s health and wellbeing from another’s. The weaknesses of the healthcare system itself compound these disparities (Dreze & Sen 2013: 143–242).

In the ten years since the inception of the National Rural Health Mission in 2005,²³ public healthcare infrastructure has improved (although it remains profoundly inadequate). Again, the distribution is uneven, exacerbating inequities in health outcomes. While 68% of India’s population lives in rural areas, 73% of public hospital beds are located in urban centres. In Goa, one hospital bed exists for every 614 persons; in Bihar one bed exists for every 8789 persons. A recent study by Powell-Jackson et al. (2013) of the quality of India’s primary care took into account the availability of services, clinical staff, training, equipment, drugs, and basic infrastructure, and found that ‘most facilities fall far short of minimum standards, with a long tail of facilities which are barely functioning’ (cited in Patel et al. 2015: 2426).²⁴ There remains a general rural shortfall of 20% of required health subcentres, 22% of primary health centres, and 32% of community health centres; Bihar and Uttar Pradesh are persistently cited as two of the states whose population suffers from the most significant shortfall in facilities. As I noted

²³ The National Rural Health Mission began in 2005, and was subsequently merged with 2014’s nascent National Urban Health Mission into a common National Health Mission.

²⁴ By the end of March 2015, only 21% of primary health centres and 26% of the community health centres were functioning as per Indian Public Health Standards (IPHS) set by the Ministry of Health and Family Welfare. Factors commonly cited as limiting the efficacy of government-run primary care facilities include distant locations, patients’ wage losses due to inconvenient opening times, high health worker absenteeism and insensitive attitudes.

above, it is not a coincidence that so many patients travel to AIIMS from UP and Bihar.

A consequence of this inadequate provision, as Patel et al. note, is that ‘public sector tertiary care institutions...not only provide valuable specialised services but also inadvertently serve as primary care providers to compensate for these weaknesses in the public health sector’ (2015: 2427). AIIMS exemplifies this outcome (see chapters 2 and 6).

The large number of self-referrals to AIIMS illustrates that such institutions exist independently of the primary or secondary healthcare system. For the vast majority of patients without privileged access to individual doctors, to be ‘referred’ to AIIMS does not involve internal communication within an integrated healthcare system. Rather, it is to be ‘sent’ (*bhej dena*) – the Hindi more accurately reflects the experience of being dispensed with by a doctor who has reached the limit of her capability (or inclination) to treat a challenging and often advanced condition and told to seek further treatment at AIIMS. Some patients are directed to seek an appointment at a particular department, while others are simply instructed to ‘go to AIIMS’. Either way, their pursuit of care reverts to square one, as they embark on often long journeys, and join the pre-dawn queue for the OPD counter which they may or may not reach on their first attempt.

Perhaps unsurprisingly, given the inadequacies of the public system, healthcare in India, both its pursuit and provision, is overwhelmingly a private enterprise. The National Sample Surveys of social consumption reveal a steady decrease in the use of public hospital services over the past two decades, with the sharpest decline predictably occurring in urban areas.²⁵ In 2014, more than 70% of outpatient care²⁶ and more than 60% of inpatient care²⁷ was provided by the private sector, while between 2002 and 2010, the private sector contributed to 70% of the increase in total hospital beds across the country (Patel et al. 2015: 2428).

²⁵ From 43% in 1995–96 to 32% in 2014 in urban centres, and from 44% to 42% in rural areas.

²⁶ 72% in rural areas, and 79% in urban centres.

²⁷ 58% in rural areas, and 68% in urban centres.

Improved incomes and concurrent upward mobility allow people to end a dependence on unreliable public services; choice of healthcare becomes an act of conspicuous consumption that speaks to one's relative wealth and status (Baudrillard 1998: 218; Fernandes 2006: 131–36; Lefebvre 2008; Patel et al. 2015: 2426). Having said that, for many patients, and for a number of doctors, an oversimplified public/private dichotomy obscures regular transit between sectors in pursuit of care and/or employment (Baru 2010; Das 2015).

Lucrative opportunities for corporate chains of large, urban, 'super-speciality'²⁸ hospitals have expanded since the liberalized restructuring of the Indian economy in the early 1990s, through tax exemptions, subsidized land allocation,²⁹ and lower import tariffs on medical equipment (Lefebvre 2008; Patel et al. 2015: 2428). At the other end of the scale, however, small local private medical practices have always been a feature of the healthcare landscape (Bala 2007; Wilson 2011: 50).

The unregulated and vastly differentiated nature of the private sector makes for uneven and unpredictable standards of care (Patel et al. 2015: 2428; Phadke 2016). Reports of 'unethical and irrational practices, such as overbilling and unnecessary prescriptions, procedures, and diagnostic tests, to generate revenue and meet targets set by the corporate hospital managements' are common at one end of the spectrum (Patel et al. 2015: 2428), while at the other, informal practitioners are accused of dangerous 'quackery' (see J. Das 2016; Pinto 2004, for a more nuanced view of this workforce).³⁰

Persistently low government spending on healthcare belies the concern professed through eloquent policy documents (Government of India 2015;

²⁸ 'Super-specialization' is an unpopular term with some doctors, who consider it a corruption of the more accurate 'sub-specialization' by the marketing departments of corporate hospitals. The term is firmly established in India's sociomedical discourse, however, including among medical students, and I use it in the thesis for this reason.

²⁹ This usually involves an obligation by private hospitals to allocate a certain number of beds for the free treatment of patients from Economically Weaker Sections (EWS) of society. The regular failure to fulfil this requirement has begun to attract media attention (Sruthijith 2015).

³⁰ Informal practitioners, with no formal medical training and unregistered with the government, are estimated to comprise 55% of all care providers. They are frequently the first point of contact for patients, particularly in rural areas. A study in rural Madhya Pradesh found that 11% of the sampled healthcare providers had a medical degree, and 53% of providers had finished secondary school (Patel et al. 2015: 2428).

Dreze and Sen 2013: 143–148). Public health expenditure as a proportion of GDP remains very low, at 1.28% in 2013–14³¹ (Patel et al. 2015: 2428; Sundararaman et al. 2016). Within several months of Narendra Modi's election as prime minister at the head of a majority BJP government in May 2014, the healthcare budget was cut by almost 20%, with the blame placed on 'fiscal strain' (Kalra 2014). More recently, a parliamentary panel reported that the budget allocation for health in the five years to March 2017 is less than half of that outlined in the Twelfth Five Year Plan (Singh 2016). Patel et al. (2015) describe the situation as follows:

The stagnation in public spending on health as a proportion of GDP in the past decade, when growth rates were high, the reduced allocations to health in 2015–16 despite bright economic forecasts, and National Health Policy recommendations to increase public investment in health to 2.5% of GDP, suggest both an absence of political will to give primacy to health in India's development agenda and a belief that economic growth by itself will lead to sufficient health gains. (2430–31; also Baru 2004).

With little choice, people compensate for inadequate public healthcare with personal 'out-of-pocket' spending on private care. In 2013, 58% of all healthcare expenditure was out-of-pocket, and almost two-thirds is spent on drugs (Patel et al. 2015: 2429–30). Often described as 'catastrophic spending', healthcare costs entrench poverty: in 2011–12, 55 million Indians were estimated to have fallen below the poverty line due to medical expenditure (ibid.; Sundararaman et al. 2016).

In this landscape of unreliable and often punitive care, the unique status of AIIMS becomes clearer, as do patients' reasons for making arduous journeys to join the queue for an appointment. It is also knowledge of this wider context that fuels my enquiry into the implications for Indian health and medicine of how its most prestigious college makes new clinicians.

³¹ China spends 3.1% of GDP on public healthcare, and the UK 7.6% (<http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS>, accessed 31/5/16).

Producing doctors

India's shortage of qualified practising doctors is well known (Sharma 2015). While the World Health Organization recommends a doctor-patient ratio of 1:1000, India currently stands at 0.7:1000.³² The Indian Government has declared a desirable density of 85 doctors to every 100,000 people – to achieve this, the country requires 49% again of its existing workforce of 691,633 doctors (Patel et al. 2015: 2427). Not all agree that training more doctors is the right priority for improving India's health outcomes and inequities, or on the specific type of doctor the country most needs (Sharma 2015). Community health centres in rural parts of many northern and northeastern states face shortfalls of specialists exceeding 80% (Patel et al. 2015: 2427). For some commentators, this is the greatest priority (Shetty 2015). For others, the most urgent need is for well-trained generalists (Ruddock 2015; and see chapter 7).

The ratio measure admits little insight into the uneven density of doctors across regions and sectors. For example, the 68% of India's population living in rural areas is served by only 33% of the country's doctors. And in 2014, only 11.3% of all allopathic doctors were working in the public sector, and of them barely 3.3% were employed in rural areas (Patel et al. 2015: 2427). Nor does the policy conversation about the doctor-patient ratio address the structures of medical education that produce this outcome (Shetty 2015). For instance, the 80% shortfall of specialists in northern states cannot be understood independently of the fact that Maharashtra and the four southern states of Andhra Pradesh, Karnataka, Kerala, and Tamil Nadu account for more than 50% of India's total seats in medical colleges (Rao & Naik 2016).

At the time of writing, in August 2016, there are 412 medical colleges in India recognized by the Medical Council of India, which together provide 52,965 MBBS seats³³, ostensibly making India the largest producer of doctors in the world. By the time of reading this figure may well have increased: between 2009

³² <http://data.worldbank.org/indicator/SH.MED.PHYS.ZS> [accessed 31/5/16]

³³ <http://www.mciindia.org/InformationDesk/ForStudents/ListofCollegesTeachingMBBS.aspx> [accessed 31/5/16]

and 2015, 98 new colleges were established and the number of MBBS programme admissions increased by 31% (Patel et al. 2015: 2427). Of the existing colleges, 190 are government owned and 196 are owned by private trusts. The majority of new colleges are private institutions, and are predominantly located in wealthier southern states, as noted above.

Different medical colleges have traditionally had different routes of entry; until 2016 there were around 35 separate entrance exams for the country's 412 medical colleges. The All India Pre-Medical Test (AIPMT) allocates 15% of seats at state government colleges on a pan-India basis – in 2015, over 600,000 students competed for 3,700 MBBS seats. Private colleges often conduct separate entrance exams, as do institutions of national importance, among which the AIIMS exam is considered the most challenging (see chapter 4). In April 2016, however, a Supreme Court ruling mandated that all medical college admissions be subject to passing a single National Eligibility cum Entrance Test (NEET) (Rao & Naik 2016).³⁴ AIIMS, ever exceptional, remains exempt.

Seats for postgraduate training are more scarce, with approximately 14,000 places for 50,000 annual MBBS graduates. As I explore in chapter 7, the MBBS degree has been devalued to the extent that few graduates go into practice without a postgraduate qualification. One consequence of this situation, which some senior figures consider a primary hindrance to the provision of adequate public healthcare (Shetty 2015), is the loss of doctors. Dr Raman Kumar, president of the Indian Academy of Family Physicians estimates that there are approximately 300,000 MBBS graduates not in full-time practice due to the relentless pursuit of a postgraduate seat.³⁵ This competition also has direct consequences for the education of MBBS students, many of who prioritize studying for postgraduate entrance exams over gaining clinical experience during their intern year (see chapters 5 and 6).

³⁴ Former health secretary Sujatha Rao is among those also calling for the implementation of a common exit exam to tackle the variable standards in medical education (Rao & Naik 2016; also, *Economic Times* 2016).

³⁵ Personal communication, 9/3/16.

Rent-seeking and corrupt practices have become synonymous with the Indian medical education sector (Patel et al. 2015: 2428; Manuel 2015), most publicly through monetized exam cheating such as that exposed in the already notorious Vyapam scheme in Madhya Pradesh (Sethi 2015). A 2015 Reuters investigation found that since 2010, one out of every six medical colleges, or around 69 institutions, have been accused of fraudulent practices, whether bribing MCI officials to pass inspections, bussing in healthy locals to pose as patients in order to persuade inspectors that students are gaining sufficient clinical experience, demanding capitation fees, or rigging exams (MacAskill et al. 2015; also D'Silva 2015).³⁶ Two-dozen colleges have recently had MCI recognition withdrawn due to unacceptably low standards (MacAskill et al. 2015). Another report showed that almost 60% of India's medical institutions had failed to produce any research papers during the last decade. Of those that did, 40% of the output came from the ranks of the country's top 25 institutions (Krishnan 2016).

Patel et al. note that 'the medical curriculum focuses on clinical applications of medicine, which, along with lucrative career options in the specialist private sector and limitations of infrastructure and opportunity in the public health-care sector, leads many medical graduates to specialise and work in the private sector' (2015: 2427). In chapter 7, I aim to add nuance to this statement by exploring some of the less immediately visible influences on student aspirations, and the obstacles that preclude the alternative futures that certain students envisage in defiance of the conventional wisdom that confirms a (super-)specialized career as the most appropriate outcome for an AIIMS student. Bearing in mind that this aspiration is common to the majority of students beyond AIIMS, I also question the role of India's most prestigious medical college in setting standards and expectations for medical practice, arguing that this is the angle from which the institution might be understood as complicit in the landscape of healthcare provision beyond its gates.

³⁶ For a brilliantly bombastic illustration of corruption in private medical colleges, see the film *Sivaji* (2007, dir. Shankar) with the Tamil superstar Rajnikanth.

Structure

In March 2016, I returned to the AIIMS campus to meet Purush and Dhananjay, who I had met during the final year of their MBBS and who were now studying for the postgraduate entrance exams. We discussed their preferred courses and colleges. Dhananjay acknowledged that studying somewhere else might lend him a broader perspective, then he paused and looked at me. ‘But AIIMS is AIIMS,’ he grinned. Simply put, what follows is an attempt to understand what this means: for students at AIIMS, for the doctors they will become, and for the sociomedical landscape beyond the institutional boundary.

Following a discussion of my methodology in chapter 2, the thesis proceeds as follows. In chapter 3, I tell the story of AIIMS as a postcolonial institution that was conceived pre-independence. Alongside the recollections of some of the institution’s earliest faculty and students, I explain how its exceptional status and its complex mandate were designed from the outset, imbricated in narratives of global scientific progress and national development.

In chapter 4, I trace the long process of gaining admission to AIIMS as an MBBS student, and argue that possession of Bourdieu’s (1986) forms of capital is necessary not only for winning a place, but even for realistically aspiring to sit the entrance exam. Drawing on the history and anthropology of Indian education, I trace the legacy of a reliance on memorization, or ‘mugging up’, in order to understand how these pedagogical orientations inform the nature and experience of the entrance exam. Following this, I introduce the concept of a ‘biographical number’ based on my analysis of the social function and subjective content of exam rankings.

Chapter 5 takes us through the gates of AIIMS and into the lives of its students. Reflecting on the discourse of ‘freedom’ that I often heard from students, I hark back to Victor Turner’s (1967) description of initiation to interpret the MBBS as a liminal period in the lives of students, which offers transformative possibilities that nevertheless contain their own limits. This thread becomes a discussion of reservation-based difference at AIIMS, and the ways in which a discourse of caste and merit slips in and out of view at the

institution, reflecting how students think about themselves and each other as citizens and future doctors.

In chapter 6, I draw on ethnographic material from wards and outpatient clinics to show how a hidden curriculum (Hafferty 1998; Taylor & Wendland 2014) operates through communication in the clinic (Ahearn 2012; Bourdieu 1991; Duranti 1997; Ram 2010), imparting to students impressions of naturalized social structures, and what it is to be a good doctor and a responsible patient. In this chapter I introduce the concept of ‘patient labour’ to illustrate a phenomenon whereby students appreciate the number and diversity of AIIMS patients as an educational asset, at an institution that conditions them to be (super)specialized clinicians unlikely to provide the frontline care that these same patients often come to the hospital in search of.

‘AIIMS killed the GP,’ a former director told me, and I explore the implications of this statement as I discuss student aspirations in chapter 7. I consider how medical practices are differently valued and legitimized, and how this informs students’ ambitions. Following Long and Moore (2013), I consider the fact of graduating from AIIMS an achievement with a social life in the present, and implications for the future, for both individual students and the networks in which they are embedded (Bayly 2013). I explore the complex discourse that steers AIIMSonians towards super-specialized urban practice as the career path most befitting the country’s ‘best’ new doctors. I end with two short stories of students who challenge this conventional wisdom by envisaging alternative futures, only to find them precluded, followed by the story of a faculty member who illustrates the enduring consequences of becoming an AIIMSonian.

I conclude the thesis by re-entangling these various threads to reflect on the existence and experience of AIIMS in imagination and practice (Pinto 2004). In doing so, I suggest that it is the complicity of AIIMS in the broader sociomedical landscape that is the most consequential dimension of the tripartite lens through which I have viewed the institution. It is from this perspective that the consequences of the determinations and contestations of

attainment and excellence at AIIMS for the contemporary politics and practice of medicine in India become visible.

CHAPTER 2. 'ARE YOU A SPY?': ON METHODOLOGY

...in things of that kind the Castle moves slowly, and the worst of it is that one never knows what this slowness means; it can mean that the matter's being considered, but it can also mean that it hasn't yet been taken up ... and in the long run it can also mean that the whole thing has been settled, that for some reason or other the promise has been cancelled ... One can never find out exactly what is happening, or only a long time afterwards. – Kafka, The Castle³⁷

In April 2014, having listened patiently to the wry and occasionally despairing account of my effort to gain research access to AIIMS, a friend gave me a copy of Kafka's *The Castle*. In the novel, K. arrives in a village believing he has been appointed as a Land Surveyor by the authorities that inhabit The Castle, which sits on a hill and pervades the life of the village. The story revolves in increasingly dizzying circles around K's efforts to have his position recognised by The Castle in order that he may begin work.

I arrived in Delhi in January 2014 believing that arrangements were in place to begin my research at AIIMS, following nine months of preparatory work. This began with an exploratory trip to Delhi in April 2013, during which time I met senior doctors and administrative staff. One particular member of the administration informed me with a blank smile that my research was out of the question, and that if I 'applied my brain' to reading the guidelines he had thrust at me, I would see the truth of the matter. Through the same contact in London who had connected me at AIIMS, I was able to appeal to the Indian Ministry of Health and Family Welfare, and I did so, though not without a sense of discomfort about the place of elite networks in the facilitation of my research. Was my credibility as an independent scholar already compromised by my willingness to utilise such contacts, I wondered. And what grandiosity of intent was implied by my willingness to badger senior civil servants into letting me conduct my research?

³⁷ Kafka (2005 [1930]): 226–227.

At the Ministry, I was escorted to a desktop computer in an assistant's office and told to write a letter to the secretary of health explaining the situation. I duly did so. From there I was ushered in front of the secretary himself, and was told to present him with the letter I had typed in an adjacent room a few minutes earlier. An early confirmation of the unassailable power of words on paper (Gupta 2012; Hull 2012).

The secretary read the letter and muttered a few things about AIIMS leveraging and resigning its institutional autonomy as it suited the circumstances. He looked up at me.

'So, are you a spy?'

Accessing the Institute

The challenge of securing research access to AIIMS was inflected with moments of comedy, suspicion, despair and triumph. The variety of strategies and personalities involved speaks to the specific characteristics of seeking permission to conduct research within a highly-respected government institution. Not that my experience can necessarily be considered typical, particularly outside India. While Phillip Abrams (1988) has written about the paradox wherein public institutions are more challenging to access than private organisations, Marcia Inhorn (2004) found gaining access to public hospitals in Egypt and Lebanon more straightforward than seeking the same permission to study private clinics. In Papua New Guinea, Alice Street describes how she was welcomed by the hospital staff as a witness to the challenging circumstances in which they worked (2014: 31).

In my case, while everything hinged on the crucial letter of official permission that was eventually written by the dean of research, personalities and the establishment of rapport – those traditional hallmarks of anthropological fieldwork (Geertz 2000) – were central to the negotiation of the institutional labyrinth. From the outset, I was extremely fortunate to have the support of a senior doctor at the hospital – Dr B – whose calm, good-humoured kindness and generosity continued throughout my fieldwork. From the outset Dr B made it

clear that he was helping me because his batchmate in London – my original AIIMS contact – had asked him to. He did express a genuine interest in my work and encouraged me to pursue it, but his initial motivation spoke to the network of relationships that enabled that pursuit. While personal perseverance was crucial, gaining research access was by no means a solo effort. I remain convinced that I would not have been granted research access without Dr B's support, and during fieldwork his existence as my very own key informant reassured me that things do occasionally materialise as the methods books anticipate (Aull Davies 1997).

My greatest adversary in the permissions process was the senior member of the administration mentioned above who had no intention of allowing my research to proceed.³⁸ During a meeting, another administrator, who was very supportive and on the brink of granting me permission, decided to consult this particular colleague who went on to explain that 'the problem' was that I might publish my research and that no one wanted to be responsible for setting in motion a chain of events potentially damaging to AIIMS. For all that he had made a significant effort to block my access to the hospital, I felt a grudging respect for this explicit acknowledgement of what lay at the heart of his objections. It was not surprising, but it had until then remained implicit. In this light, the administrator perhaps proved to be the person most conscious of the potential power of ethnography as a method, which, as Fassin (2013) notes, may be perceived as warranting 'avoidance, suspicion or prohibition' precisely 'because it allows witnessing where those in power do not want evidence of what is ongoing to be seen' (630; Inhorn 2004: 2096).

Nevertheless, once I had official permission to conduct my research, not all doctors found my methods either threatening or alien. When I explained my request to one head of department, he nodded and replied, 'You want to do participant observation.' The research culture of AIIMS, while strained by the demands of clinical care, is an important facet of the institution's identity, and I suspect this inclination informed the encouragement of my work by certain

³⁸ See Inhorn (2004: 2097) on such archetypal powerful individuals.

faculty members, even if it was in a very different vein to their own (see Inhorn 2004: 2100 for her reflections on a similar experience at a university hospital in Cairo).

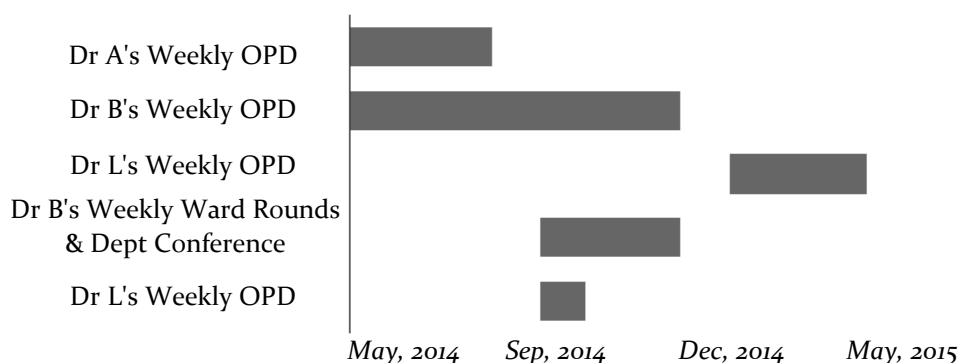
To my relief, that particular meeting concluded with the agreement I would need a senior faculty member to vouch for me with the director.³⁹ True to form, Dr B was generous enough to agree to take responsibility for me, provided I promised 'to be good'. This was meant in jest and was a reflection of the rapport that had grown between us, but it also spoke directly to my discomfort about the implications of Dr B's role for both him and me. When does affection for one's chief informant, or concern for the impact of one's research upon that individual, risk compromising the integrity of the work produced? Or, perhaps, when does integrity regarding these sometimes ambiguous relationships that straddle the border between the professional and the personal conflict with that pertaining to one's scholarship? In her response to the 'ontological turn' in recent anthropological theory, Liana Chua (2015) reminds us of the importance of what she terms 'co-presence' in the production of anthropological knowledge. If, as Fassin argues in turn, ethnographic research is in part a process of accumulating debts and the 'intellectual production' that follows a means of repaying them (2013: 640), or if, in Inhorn's characterization, the anthropologist in a hospital setting cannot avoid being the client in a patron-client relationship (2004: 2097), then to what extent do we risk embedding compromise within our scholarship from the outset? This potential quandary briefly resurfaced when I was finally granted access to AIIMS and felt my critical capacities smothered by sheer joy and gratitude at being a legitimate presence within the institution. The greater distance enforced by the writing process, however, allowed for the co-existence of a critical analysis of student life at AIIMS with explicit gratitude towards the actors implicated in both this practice and the facilitation of my research.

³⁹ I had a single meeting with the director, which resulted in one of the more disorientating moments of my long effort to gain access as he sent me back down the chain of command to the dean I had begun with a year earlier but whose post had since – fortuitously, it turned out – been occupied by a different faculty member. I attempted to meet the director for an interview before I left Delhi, but I received no response to my requests.

I began ‘fieldwork proper’ in early May 2014, and I left Delhi one year later. The dean who wrote the official permission letter told me that he would inform the director of his decision, although I am not sure whether that ever transpired. The promised formalization of my position under the auspices of the Research Department never occurred, but the letter of permission acted as my passport into the institution and continued to serve its purpose throughout my fieldwork. The only challenge arose in my final few months when I sought access to Dr L’s OPD. Dr L insisted that I return to the dean and have the letter annotated to reflect the fact that the appropriate authority had sanctioned my presence in her specific clinic. A different faculty member now held the dean’s post and I feared having to stop work as I renegotiated access at such a late stage. A brusque greeting gave way to unequivocal support, however, and I returned to Dr L, who rather reluctantly allowed me to observe her clinic over several weeks. The letter’s envelope had fallen apart by the time I left Delhi; the letter itself, also beginning to disintegrate, remains a precious souvenir and a symbol both of perseverance and of the willingness of certain individuals to open their institution to scrutiny by a stranger.

The table below illustrates the structured periods of observation that I undertook during my year of fieldwork; these existed alongside the time I spent on campus, whether conducting interviews at the coffee shop, spending time at Pulse (the annual student-organized festival), or generally milling around between appointments.

Table 2. Structured observation periods.



The anticipated challenge of gaining access to AIIMS lent additional necessity to the anthropological method of entering the field with a sufficiently open mind to allow for unanticipated revelation and shifting lines of enquiry. I was concerned not to ask anything more of the AIIMS administration than general permission to observe and interview doctors, students, and patients – anything more specific, pertaining to a particular department for example, may have led to further obstacles. But I was also motivated by a deliberate decision to exclude certain areas of research, particularly those concerned with a specific disease or condition such as cancer (Macdonald 2015) or HIV/AIDS (Van Hollen 2013),⁴⁰ and a predominant focus on patients. This latter decision was partly logistical. My Hindi was not sufficiently fluent to converse with or interview patients without the support of a research assistant.⁴¹ Plus, I was immediately disabused of a vague vision of engaging with patients following consultations. The speed of consultations, the crowds, and the intimidation of being pursued in the corridor by a (foreign) stranger and asked to participate in a research project made this impractical. There was no room for sufficient sensitivity, either to the patients or to the doctors whose consultations I would have been constantly disturbing.

I recruited Preeti, my research assistant, from JNU, where she was studying for an MPhil in history. Preeti assisted me in conducting short interviews with patients as they waited at various spots around the hospital, and transcribed these as English translations – I retained the Hindi originals for clarification purposes. Preeti also helped arrange interviews with some senior residents at AIIMS, which I conducted alone in English, and she also did some archival work at the Central Secretariat Library. I describe Preeti's role not only to act against the 'silencing' of assistants that some researchers are guilty of (Turner 2010), but also to shed light on my experience of conducting fieldwork with a chronic illness. I expand on this below.

⁴⁰ This was by no means a rejection of this crucial work, but rather a means to differentiate my own approach to questions of health and illness.

⁴¹ Despite having undergone a certain amount of Hindi training, I was aware that my language skills were not sufficiently competent to conduct in-depth interviews alone, particularly with patients at AIIMS who, coming as they do predominantly from across North India, speak a variety of Hindi dialects.

In total, Preeti and I conducted 78 short interviews in which we asked about why the patient (or attendant) had come to AIIMS, details of their journey to the hospital, their preconceptions and experiences of the institution, and their thoughts about the role of the government in healthcare provision. These patient voices are predominantly audible in chapter 6, and many of them hint at longer stories that deserve to be heard. To place patients at the centre of my study, and to do justice to the complexity of their AIIMS experiences, however, would have demanded that I follow them through the gates and into their local worlds to understand the therapeutic repertoires of which AIIMS would only be a part. Such work has been conducted in Delhi communities to an exemplary standard by Veena Das (2006, 2015), providing invaluable context for thinking about the lives of AIIMS patients beyond the hospital, and there is clear scope for future work in this vein. For this thesis, however, I chose to remain predominantly within the institution's gates out of a desire to offer the anthropology of health and illness in India a perspective on the ways in which doctors are produced at AIIMS, and the possible consequences of these processes.

The students

The majority of the students that populate this thesis were, at the time of my fieldwork, in the fourth or fifth year of the MBBS course at AIIMS. I also spoke with junior and senior residents and recent graduates, but in much smaller numbers (see table below). As the map in the introduction shows, AIIMS students present a more pan-Indian face of the institution than do patients, particularly given the significant number of students from Kerala, although North Indians (and Hindi) still predominate.

The fourth-years were in their final two semesters of taught curriculum, while the fifth-years had completed their final exams and were accumulating clinical experience as interns rotating through departments, at least in theory.⁴²

⁴² The intern year is used by many as an opportunity to study for the postgraduate entrance exams at the expense of gaining greater clinical experience. See chapters 6 and 7.

I first encountered the fourth-years during my visits to the Comprehensive Rural Health Services Project, run by the AIIMS Centre for Community Medicine, at Ballabgarh in now peri-urban Haryana, in September–October 2014. A group of 15 students had just begun their seven-week posting and I accompanied them on their outreach and learning activities in local villages, becoming in the process more committed to my increasing focus on education at AIIMS. I went on to conduct interviews with several of these students, expanding my efforts via snowballing and the class email list given to me by the class president. I met the interns at the AIIMSonians (alumni association) picnic in February 2015, and conducted interviews with students in the months that followed.

The group I met at Ballabgarh had just begun their fourth year of study and brought to our interviews sufficient experience to be able to reflect on their time at AIIMS and to consider the increasingly imminent post-MBBS future. The perspective of the interns I encountered a few months later was similarly informed, but with the notable difference that the post-MBBS future was now very real, with a consequent undoing, for some, of the certainty they had felt about their career aspirations a year earlier. These two groups of students therefore brought reflections both on what was behind them and what was to come. Given these advantages, but also the pressure of limited time, I chose to focus on developing relationships with, and an understanding of, these cohorts. The obvious consequence of this approach is that students in their early years at AIIMS are not represented in my discussion. In future research, I would like to explore the experiences of younger students, perhaps with an eye to a longitudinal study that tracks how attitudes towards medicine and doctoring evolve during the MBBS.

All the students cited in the chapters that follow were interviewed in-depth in a semi-structured format; interview lengths were largely determined by responses and ranged from twenty-five to seventy minutes. I engaged with several of these students on more than one occasion following the initial interviews and during my short follow-up visits to AIIMS in September 2015 and March 2016. The majority of interviews with the MBBS students took place at the outdoor campus

coffee shop, which had the advantages of being easily accessible for students, while allowing me greater immersion into campus life and also, in time, facilitating chance meetings with students I had come to know. These encounters inform the fabric of my broader ethnographic material to which casual unstructured conversations – whether at the coffee shop, around the hostels, or on the bus to Ballabgarh – are integral.

Securing meeting times could be challenging. Faculty members and senior residents had extremely busy and often unpredictable schedules; younger students, on the other hand, had to balance the demands of academic and social lives (and sleep), and while many were generous with their time – and some were demonstrably anxious about keeping me waiting – others were harder to pin down (see Wendland 2010: 233 for similar experiences, albeit with the additional challenge of scarce mobile phone ownership among Malawian medical students). I quickly confirmed that the phone was more efficient than email, and Whatsapp was the most popular mode of communication. Nevertheless, there were the inevitable last minute cancellations, and silences in response to my attempts to set an interview date with students who had previously agreed to meet quite enthusiastically. Unfortunately, several of these cases were of female students who I was particularly keen to interview, given the significant male skew among my interviewees, and the minority status of women at AIIMS. In potential future research at AIIMS I will determine to rectify this imbalance, which will also allow me to comment more comprehensively on gender dynamics at the institution (see chapter 5).

I am also conscious of the weaknesses of depending on self-selecting interview subjects, even while aware that I could not compel participation, and knowing that some students agreed more reluctantly than others. The voices heard throughout this thesis belong to students with opinions and experiences that they were willing, and sometimes extremely keen, to share with me. I cannot know how the experiences of students unwilling to speak to me might contradict or complement my analysis. Had I spent more time socializing in the student hostels I would likely have accrued a greater number of casual informants. As things stand, however, I have tried to present both diversity and

commonality of experience within my group of students, and I am content to acknowledge the partial truth of any ethnographic endeavour (Clifford 1986). While, when thinking about interview-rich research, I follow Claire Wendland's reflection that '...I have to assume both that students were the best source of evidence about their own process of becoming doctors and that some evidence was missing or misleading' (2010: 235).⁴³

In addition to students, I also conducted in-depth semi-structured interviews with current and retired faculty, with two members of the first AIIMS MBBS class, and with external actors. The complete set of in-depth semi-structured interviews I conducted from May 2014 – May 2015 is enumerated in the table below.

Category	Interviewees	Male: Female
Third-year MBBS	1	1:0
Fourth-year MBBS	15	13:2
Fifth-year MBBS (intern)	11	8:3
Graduate (class of 2009)	2	2:0
Junior Resident	2	1:1
Senior Resident	4	4:0
PhD Student	1	1:0
Current Faculty	10	9:1
Retired Faculty	3	1:2
Class of 1956 Graduates	2	2:0
AIIMS Raipur Faculty	2	1:1
JSS Founder	1	1:0
Max Healthcare Directors	2	2:0
Former Health Secretary	1	1:0
	Total: 57	47:10

Table 3: In-depth semi-structured interviews

⁴³ As Wendland notes, a longitudinal approach is in many ways the ideal method for a study of doctors-in-formation, but faced with the logistical constraints of limited time and funding this is rarely possible (2010: 229). In her work on reservations in medical education in Maharashtra, Dandekar did seek out graduates of the college she had studied (although no one she had known as a student) in order to track career trajectories and lifestyles (2013: 128–29).

On return from Delhi, I began the analysis of my material by manually coding all interview transcripts and field notes under a sufficiently expansive range of themes to maintain complete visibility of the material, and allow it to speak for itself. Certain themes were already clear, having become central while I was still in the field. This was particularly true of students' experiences of seeking a place at AIIMS (chapter 4), and the aspirational trend towards super-specialized practice (chapter 7). Others revealed their importance more during the analytical process and tended to be the outcome of various sub-codes speaking to a larger theme. Caste, especially, proved to be a more prominent theme than I had anticipated once I was in a position to juxtapose interview transcripts with existing literature about caste and education (chapter 5). This was also true of the ways in which the hidden curriculum acts to inform students' impressions of exemplary medical practice, and the patient-doctor dynamic (chapter 6).

The framing argument of the thesis – that AIIMS is simultaneously insulated from, permeated by, and complicit in the landscape beyond its gates – had begun to take shape during the final period of fieldwork. In retrospect, I find I adhered in a vague sense to – and now certainly agree with and will employ in future – Kim Fortun's advice:

Texts need to be imagined as we move through the field, directing our attention to the kinds of material we will need to *perform* an analysis. This means that we also must imagine narration and argument as we go, even while remaining open to the field's beckoning, answering the field's call, recognizing that its intricacies will take us where theory never could. The prospect of writing can orient without determining our enquiries. (Fortun 2009: xii).

On hospital ethnography in particular

While community studies of illness experience and health-seeking behaviour are well established in India, hospital ethnography is a nascent subfield and one that I was, and remain, keen to contribute to. Its particular methodological challenges are myriad. Gitte Wind (2008), and van der Geest and Finkler (2004),

highlight the main challenge that hospital ethnography poses to the technique central to the anthropological method: participant observation. Reflecting specifically on her experience of conducting ethnographic research in hospitals, Wind troubles the casual deployment of 'participant observation' by researchers in situations in which they cannot effectively participate in what they are observing. Van der Geest and Finkler (2004) note examples of ethnographers who have deliberately participated in hospital life and written from the perspective of doctors and nurses, visitors, and even patients – as well as those, like myself, who occupied a more ill-defined liminal space during their research. While it is arguable that simply by being present I was participating in the life of AIIMS, I did not participate in the activities I observed. I was not a patient receiving care, a doctor providing it, or a student learning how to do so.

Rather than be left simply with 'observation' as a means of describing her research – which belies its interactive, engaged nature – Wind suggests 'negotiated interactive observation' as a more accurate, if cumbersome, terminology (2008: 83). On the whole, however, while this theme has been a preoccupation since the discipline began to venture beyond the notion of a bounded village to encompass a broader variety of field sites (Gupta and Ferguson 1992; Marcus 1995), particularly those defined by forms of expertise, the general consensus about 'participant observation' as a valid description of an anthropologist's primary activity seems intact.

Wind describes her position in the Dutch rheumatism clinic that she studied as dependent on 'a daily on-going negotiation, which sometimes went well and sometimes did not' (ibid.). Some staff members were delighted by her presence and interest in their work. Others were puzzled by her research, anxious, or suspicious that they were under surveillance (ibid: 83-85). Similarly, Zaman's (2005) research participants in a Bangladeshi hospital sought an explanation of the practical utility of his work, and Nichter (2008) faced the same demand from a policy-maker in India. At AIIMS, once I had the talismanic permission letter in my hand, I was on the whole made welcome; doctors would comment to me during an OPD, and encourage my questions. Occasionally I was aware I was being humoured for the sake of the authoritative signature on the

letter, and when it came to observing Dr L's OPD, I had to renegotiate permission and never escaped her occasionally unnerving suspicion of what I was writing in my notebook. More often than not, I felt awkward about the additional demand I was placing on these doctors already working under significant pressure, and quite overwhelmed by their generous accommodation as an additional chair was manoeuvred into an already cramped consultation room.

I chose not to seek permission to observe students during classes. Aside from the challenge of seeking further necessary permissions, I decided to remain focused on life outside the classroom, as my interest was less in how students were explicitly taught biomedicine at AIIMS and more in the less tangible influences on their formation as doctors.

Ethics

As per the requirements of the King's College Ethics Committee, my research participants have been made anonymous through the use of pseudonyms. It is possible to argue that true anonymity of participants throughout the thesis could only have been achieved had I anonymized AIIMS itself. This is feasible in studies of phenomena that are not germane to a particular institution, but where the research is interested in the life of a specific hospital, particularly one with a high public profile such as AIIMS, any attempt at anonymization would have eviscerated the work of its intended substance.

Identifying the institution, however, does make anonymization of particular actors more challenging (see van der Geest 2003 on the dilemmas around confidentiality). Some students found the prospect of anonymization amusing, and assuming it to be an impediment to my work, gave permission to use their real names (which I have not done). Faculty members welcomed anonymity and I extended this to include their choice of professional designation (e.g. senior member of the AIIMS administration). While I have not specified the names of the departments in which I observed outpatient clinics (OPDs), it may be possible to deduce their identities through my descriptions if

a reader was so inclined. Identification of individuals is also made more possible through gender pronouns, which I have not disguised, as this would have meant homogenizing all gender pronouns as either male or female, which would have demanded its own comment and analysis. Similarly, while I have anonymized names, the excerpts from interviews with retired faculty include details that may aid identification. I have omitted details according to participants' wishes at the time of interview, but certain remaining details are important for context, and in these cases I resort to the consent forms that all such participants signed and which explained the nature of the project and their right to retract any information shared up until my departure from the field.

Not all research participants signed a consent form, however. As I explained in my application to the King's College Ethics Committee, echoing numerous voices before mine, a stranger asking a patient at AIIMS, likely to be of low socioeconomic status and minimal formal education, to sign a document is an act with profoundly unsettling implications. When Preeti and I approached patients, we explained my identity and reasons for wanting to engage them, and sought solely their verbal consent to ask a few questions. Not unexpectedly, some people preferred not to speak with us, and of those who did engage, some were far more forthcoming than others. We regularly had to clarify that I was not working on behalf of AIIMS, but I cannot be sure that everyone understood this. This fact, together with the brevity of the interviews, and the visible preoccupation of many people with the stresses of a long wait in crowded, often uncomfortably hot surroundings while unwell, confirmed my feeling that it would not be realistic to properly engage with patients solely within the bounds of the hospital. This is not everyone's experience. Marcia Inhorn describes the written consent form as a tool that she found helpful for 'breaking the ice' with her informants, and also for explaining in detail the nature of the project and the protection of confidentiality (2004: 2099). Inhorn was certainly helped in this endeavour by the provision of a private room in the hospital within which to conduct interviews. At AIIMS, the crowds and consequent visibility would likely have made our interviewees more self-conscious had we spent several minutes

explaining the consent form and attempting to publicly coax a written indication of agreement.

The limits to informed consent that I had anticipated in my ethics application were confirmed most clearly in the context of my observations of OPD clinics and ward rounds. As Charles Bosk notes in his own reflections on conducting ethnography in hospitals, to seek informed consent in certain situations would be disruptive and intrusive, and ‘so socially bizarre that it would make fieldwork impossible to complete’ (2001: 211, cited in Bell 2015: 5).⁴⁴ This would have been the case in the OPDs and on the wards at AIIMS. As it was, the consent of a particular doctor to observe an OPD or ward round became a *de facto* consent on behalf of the patients under their care. While by no means unique in research in similarly crowded medical environments in the Global South (Inhorn 2004; Ram 2010), this situation, which harks back to the days of anthropologists negotiating access to a village through its headman or elder, forces the researcher to become part of the institutional hierarchy she aims to study and is an ethically challenging position. Patients inevitably assumed I was a doctor and on a handful of occasions a patient would attempt to engage me with the details of their case, prompting a no doubt puzzling clarification that I was not in fact a medical professional.⁴⁵ In attempting to apply an ‘ethnographic gaze *on the medical gaze*’ as a means of interrogating power structures (Inhorn 2004: 2096), I became complicit with these same structures that subordinated patients’ agency to that of the doctor. Was this a form of duplicity I accepted in the name of my research goals? If part of my intention in this thesis is to illuminate the doctor-patient power dynamic that is imparted through education at AIIMS, is this sufficient justification for my complicity with this dynamic? In chapter 6, I introduce the idea of ‘patient labour’, which understands patients as a resource, who, through illness and treatment-seeking

⁴⁴ Bosk’s personal ethical concerns with ethnography extend beyond informed consent to condemn the whole enterprise as inherently unethical for misleading research participants as to the ultimate goal of a project, which is usually something more complexly interpretive than is presented during the process of gaining consent.

⁴⁵ See Street’s description of patients in Papua New Guinea viewing her as another ‘hospital technology’ that might lead to attention and treatment (2014: 32). Also Pinto (2004), on being mistaken for a doctor during her work in rural North India, and Kirkpatrick (1980) for her experience as a presence on the ward of a hospital in Punjab in the 1960s.

as forms of labour, offer educational value to AIIMS students. If I follow this logic, then am I also benefitting from this labour by patients who unknowingly informed the writing that will lead to my gaining a doctorate? I do not, at this point, have conclusive answers to these questions⁴⁶, and I suspect they will remain elusive.

Disability and fieldwork

Debates about reflexivity and the influence of the anthropologist's positionality on her field of study, both in the doing of fieldwork and the writing about it, has been a preoccupation of the discipline since the 1980s (Aull Davies 1999; Clifford & Marcus 1988; and see Lynch 2000 for a challenge to what he considers the assumption of virtue embedded in reflexivity). More recently, there have been efforts to de-centre the discipline to make room for the human being who exists within and alongside her identity as an anthropologist. Doing so has facilitated valuable discussion about the influence of gender, sexuality, and ethnicity on ethnographic practice and writing (Banks 2007; Davis & Craven 2016; Enslin 1994; Lewin & Leap 1996). I would like to expand the capacity of this conversation to include the impact of disability on anthropological practice, and to mount a challenge to the persistent if often tacit narrative of the heroic body of the anthropologist.

There were several classic processes that played out during my fieldwork, just as I had been told they would. Most notably that just as I felt fully immersed in the field I would have to leave, that I would end up with more material than I could use, and that I would nevertheless be consistently paranoid that I could have done more, seen more, talked to more people, taken more notes. I did indeed feel that the field had fully opened-up to me as I was preparing to leave; this thesis is framed by an inevitably limited range of themes and consequently a substantial amount of material awaits future expression in a different form. I

⁴⁶ Kirsten Bell's (2015) thoughtful article about what she considers the incommensurability of informed consent and research ethics, with particular reference to ethnographic practice, explores such questions in much greater depth than I am able to here.

read nothing, however, before entering the field, that spoke to the reality of being an anthropologist with a less than fully able body. I have had a fluctuating chronic illness for twenty years and it has an influence over all areas of my life – including fieldwork.

During my time in Delhi, I spent an average of one day a week housebound due to illness, and had to cancel sought-after interviews on more than one occasion. While anxious that I was not ‘doing enough’ I was also aware that to over-exert myself would have jeopardized my longer-term health and therefore the whole project. The post-fieldwork exhaustion that some fledgling anthropologists boast of was not a state of being that I could risk on top of the pathological fatigue that is a key symptom of my illness. This forced me to break with one rite of passage of the anthropology PhD process and enlist my research assistant, Preeti, to transcribe my interviews and assist with unearthing archival and library resources, in addition to her role as interpreter during patient interviews.

My illness was inextricable from my fieldwork experience, and is perhaps – without indulging too much self-analysis – integral to my enduring research interest in health and medicine. I do not want to exaggerate the influence of my condition on my view of the field, and I have deliberately not incorporated such reflection into the chapters that follow.⁴⁷ Nevertheless, it is accurate to say that I experienced moments of empathy with patients that were made painful by the gulf between our socioeconomic realities – while we may have shared symptoms, I did not have to endure a raft of additional discomforts and resource pressures as part of my treatment-seeking in Delhi. Such moments expressed the reality of the AIIMS experience for patients in a way that made, while not necessarily a more accurate, certainly a more emphatic and affecting impression than could be accessed through sympathetic observation and interviews alone.

⁴⁷ In a more transient example, Sarah Pinto (2008) weaves her own pregnancy through her narrative of birth and loss in rural north India and reflects upon the influence it has on her research with rural women, up to and including the point at which she is compelled to return home to the US for medical care. My illness makes no similar appearance in this thesis, but it is an interesting exercise to consider how it might have done had I chosen to write it into visibility (see Narayan 2012: 93–110 for reflections on this theme).

Nor was the influence of my illness limited to fieldwork. Its existence influenced my relationships within the university from the beginning of my PhD, and on return from fieldwork, its often unpredictable demands have dictated the pace and rhythm of writing, as also its circumstances. I do not make these remarks as any form of disclaimer, but rather to make my own contribution to the humanizing of the anthropologist by acknowledging the influence of chronic illness on my personal fieldwork practice and the writing it has led to.

CHAPTER 3. IMAGINING AN INSTITUTION

In September 2014, I attended Pulse, the annual student-organized campus festival at AIIMS, self-described as ‘the largest socio-cultural-literary-sports festival of the medical fraternity in Southeast Asia’.⁴⁸ Pulse is a mammoth, week-long affair; its programme includes celebrity entertainment, and the festival attracts sponsorship from banks and multinational corporations. It attracts medical students (‘medicos’) from colleges around the country, and I took the opportunity to ask some of the visitors about their perceptions of AIIMS. Their responses illustrate the apparently unassailable reputation of the All India Institute as the country’s ‘best’ medical college.

Well it's a good college; obviously it's our dream college. We want to join it.

– 2nd year MBBS, Government Medical College Kota, Rajasthan

They are best in everything...the best doctors are over here. Many things.

– 2nd year MBBS, CM Medical College, Chhattisgarh

Best in India. Maybe best in Asia...Quality of education, lifestyle, thinking, everything...

– 3rd year MBBS, Assam

AIIMS, we call it medical heaven of east...when we take coaching for medical test, we dreamt to study in AIIMS, but can't reach....AIIMS is a very good institute.

– 2nd year MBBS, Government Medical College Haldwani, Uttarakhand

When I asked these visiting students what made AIIMS the best, the most common responses cited the quality of doctors and medical practice, resources and technology, the diversity of patients and diseases, and the self-perpetuating fact that it attracted the nation’s ‘toppers’ (those ranked highest in national exams). I will attend to each of these facets in the following chapters. For this chapter’s purpose of situating the institute in historical context, however, the following

⁴⁸ <http://pulse-aiims.in> [accessed 11/4/2016]

comment by an MBBS student at the Government Medical College in Jammu provides an entry point:

Actually it is the first college, which was established as a medical college in India. So it has got everything. In our colleges, they are missing lots of things. But here you will get everything that you want.

In fact, AIIMS was far from being India's first medical college.⁴⁹ At the moment of independence in 1947, India had 22 medical colleges, and by the time the first cohort of AIIMS MBBS students graduated in 1961 this had risen to 57. But more interesting than the student's misperception is that his assertion speaks directly to the stature of AIIMS in the contemporary imagination, as also of the association of value with longevity. For this student, it is logical to assume that AIIMS was India's first medical college, which all subsequent institutions continually strive to emulate.

*

In what follows, I focus on the story of medical education in India – and specifically that of doctors trained in Western medicine – beginning in the colonial period⁵⁰, in order to outline the historical context that preceded the laying of the AIIMS foundation stone in 1952. I deliberately use the description 'Western medicine', rather than the more contemporary 'biomedicine', in adherence to the terminology used during the period in question. The term became more contested after 1947; Nehru preferred 'modern medicine' as a means of signifying the cutting edge scientific knowledge that developed as a result of efforts in both the 'West' and the 'East' (see Jawaharlal Nehru's

⁴⁹ Calcutta Medical College and Madras Medical College were both inaugurated in 1835, and both replaced pre-existing colonial institutions (Madras didn't accept Indian students until 1842). The Ecole de Médecine de Pondichéry was established in 1823, but initially existed solely to train French citizens for colonial medical practice. The Indian central government took over the college in 1956, renaming it the Jawaharlal Institute of Postgraduate Medicine and Research (JIPMER). JIPMER remains one of the country's most highly regarded institutions.

⁵⁰ Of course, the history of medicine and healing in India begins with the region's earliest populations, and its trajectory demands a thesis of its own – see Bala (2007) for an overview.

Speeches, Vol 2: 550). This chapter's historical tale is interspersed with the recollections of some of the institution's earliest faculty members and students, which illuminate through personal narrative the themes of optimism and nation-building apparent in the secondary literature.

Roger Jeffery (1988) suggests that the hierarchy of medical policy under the British colonial regime in India was headed by medical education, followed by medical services, and finally public health. There is a general consensus among historians that healthcare in colonial India was predominantly enclavist in nature, although never exclusively, and that it originated with a concern for the number of British troops who sickened and died in the encounter with unfamiliar pathogens⁵¹ (Arnold 1993; Harrison 1994; Jeffery 1988). The slow shift to a concern with the health of the Indian population was largely provoked by epidemics of cholera and plague in the late nineteenth and early twentieth centuries.⁵² On the whole, the colonial approach to public health in India was insubstantial and ineffectual, and reflected the administration's reluctance to intervene, for reasons usually cited as either political or economic, but which appear more often to be an amalgam of the two (Amrith 2006; Arnold 1993; Harrison 1994; Jeffery 1988). Unsurprisingly, the history of medical education in India is also one of political economy, and of contested forms of knowledge and power.

Recollections of the beginning (1) – Dr S

I qualified from Lady Hardinge Medical College. In those days that was the only medical college in Delhi. And after that I went to what was called in those days Irwin Hospital, because I wanted to specialize in surgery. After doing my house job, I was planning to go to England like everyone else, to do FRCS (Fellowship of the Royal College of Surgeons). Due to many reasons I could not go immediately. Because this institute was coming up, and my mother was a politician ... I knew

⁵¹ Madras Medical College was preceded by the Government General Hospital, established at Fort St. George in 1664 to treat soldiers of the British East India Company.

⁵² David Arnold cites Ira Klein's description of the 'woeful crescendo of death' that swelled in India from 1871-1921; the mortality rate increased from 41.3 per 1000 in the 1880s, to 48.6 per 1000 in 1911-1921 (1993: 200).

the ruling elite in those days very intimately. The All India Institute of Medical Sciences had already been planned. And Rajkumari Amrit Kaur was the President of the Institute. She told my mother (I should say I was a political...actually I shouldn't call it 'victim' now but at that time I felt) that if our children go abroad to study, who will study here? So I was forced to explore the possibility of getting a job here. And they did not have any clinical departments; they had just started basic sciences. Since I wanted to be a surgeon, I liked anatomy very much, I applied for a job in anatomy. And I was interviewed very informally on a Sunday, and I was selected for the post of what they called a tutor, the junior most teacher in the Department of Anatomy. And I think I joined the All India Institute of Medical Sciences on 2nd February 1957.

...it was highlighted everywhere – it was going to be the best institute. I was told that a delegation went around the world, picking up and interviewing outstanding Indians in different medical colleges in England, in USA. And the professor that they had selected for anatomy was an outstanding professor, Professor NH Keswani, and he was also awarded Outstanding Achievement Award by Mayo Clinic. So the name of Mayo Clinic in those days, and hearing these very westernized people, young people, without much of that old culture of 'yes-sir no-sir' appealed to me very much. So I was offered the job and I took it. And before I knew, I was deep into research ... In my early days the atmosphere in the Institute was very nice. It was like a family. And the students, you did not treat them as students, everybody knew everyone...I mean the first batch of students, they must have attended my wedding, they were all there you know! That's why I started liking it and continued to work here. The place certainly was very congenial; it was not like any other place.

[The administration asked for] feedback from the students about the teachers, and things, everything, very modern techniques. [They] introduced a very, very excellent course, a detailed course, on neuroanatomy. In those days, hardly any neuroanatomy was taught anywhere ... There was hue and cry from everyone, that why – do you want to make everybody a neurosurgeon or what? ... But now neuroanatomy is important everywhere. So the influence in the medical education, of the Institute, was great. There was a lot of resistance from other centres – that this fellow is teaching, he is American, he is loud, he doesn't know, and she from Oxford has her head in the clouds and things like that. But finally the entire country picked up the methods of examination and teaching in basic sciences, at least in anatomy from the Department of Anatomy. And then the huge number of postgraduates that have gone from here to there, they are all over, and they are following the same methods of teaching and research.

The only thing is it was meant to be a referral centre, it was not meant to be a general hospital. When it started, it was meant to be a referral centre. And that character could not be kept due to reasons, probably, pressure of population, or patients or whatever. If it had remained as a referral centre, it would have been easier for people to work. I feel sorry for those clinicians who are seeing loads and loads of patients, you know. I mean it's not fair to expect them to work under these conditions. Otherwise so far I think it's holding on, it's bursting at the seams, but it's holding on.

Early institutions

The Indian Medical Service (IMS) originated with the ‘surgeons’ placed on East India Company ships – a service organized by the company’s own surgeon-general as early as 1614. Initially, doctors worked on particular vessels and were occasionally asked to remain at one of the company’s Indian warehouses if a merchant requested it. By the 1670s, they were recruited specifically to serve the company’s civil employees in India, and by the time recruitment began for its standing army in 1749, it recorded thirty ‘medical men’ in its Indian employ. Between the newly established Medical Services of Calcutta, Bombay, and Madras, the numbers of medical employees grew significantly from 1763 onwards – by 1823, there were 630 commissioned officers in the medical departments of the three presidencies (Jeffery 1988: 60–61).

Until the 1850s, employment as a doctor did not demand any official medical competence; before 1800 only 6% of recruits had attended a medical school, and at least half had no qualification of any kind. By 1860, however, most recruits had gained a diploma from the Royal College of Surgeons (RCS) in London. Competitive examinations for entry to the IMS were first held in 1855 and were theoretically open to Indians⁵³ – the first Indian became a member of the RCS in 1861 – but the location of the examination centres in London ensured that in practice only 55 Indians had entered by 1913⁵⁴ (ibid.: 64; Madan 1980: 19). Some of these early recruits resigned from the service within a short period of time, citing discomfort among discriminatory British officers; this criticism would become more audible during the 1920s and 1930s (Jeffery 1988: 64)⁵⁵. Even as the

⁵³ A select few Indians had been going to England for postgraduate study since 1844 (Madan 1980: 19).

⁵⁴ There are contemporary echoes of this structural impediment in the USMLE, the exam that Indian students must take to qualify for postgraduate training in the US. The later, clinical, stages of the multi-step exam only take place in the US, dictating who can and cannot attend on financial grounds, with clear implications for the socioeconomic demographic that tends to migrate from India (see Kaushik et al. 2008).

⁵⁵ In 1913, 5% of the IMS was Indian; following the introduction of a minimum quota for Indian recruits in 1919, the figure grew to 37% by 1938. However, Jeffery attributes this rise more to a shortage of British applicants, given improved employment prospects for doctors in Britain, and a perceived threat to senior positions inherent in the 1919 reforms, than to a willingness to cede more control to Indian medical officers. This earlier history of objections to the introduction of

administration of local health policy and bureaucracy was devolved to the provinces, the colonial government retained central supervision of the IMS, rather than allowing nationalist politicians further autonomy. This arrangement engendered deep suspicion of the IMS and likely informed the decision to abolish it in 1947 and distribute power over medical civil servants to local government (ibid.: 66–68).

Before 1860, other than at the colleges established in Calcutta, Madras and Bombay in the 1830s, medical education in India generally took the form of apprenticeships (as it did in Britain). Between 1860 and 1914, the IMS determined and controlled the hierarchy of medical education. Medical *schools*, which offered short courses for employment in auxiliary medical services, were subordinated to medical *colleges*, the courses at which led to university qualifications that allowed a student to take the IMS exam, and whose degree (from 1892) was recognized in the Colonial List of the General Medical Council in London.

In Calcutta, the Native Medical Institution was established in 1822. Students were taught European medical texts in translation to Indian languages (as was also the case at the Sanskrit College and the Madrasa), and they also took classes in the indigenous medical systems of Unani and Ayurveda. Dissection was carried out only on animal bodies, a fact that would prove central to the closure of the institution.⁵⁶ This arrangement reflected a broader political atmosphere in which the parallel existence and occasional syncretism of Western and Indian knowledge systems was tolerated by the colonial administration, and expressly promoted by the so-called ‘Orientalists’ of the era. An attitudinal shift was expressed in both the unfavourable report on medical education requested by William Bentinck, Governor of Bengal, in 1833, and Macaulay’s Minute on Indian Education in 1835, which argued for the promotion

recruitment quotas is generally forgotten in the discussion of more contemporary agitations against similar policies (see chapter 5).

⁵⁶ See Bala (2007: 27) for more on the historical politics of dissection that belie the colonial assumption that Indian indigenous practitioners were averse to the practice by definition. Also see chapter 6 of this thesis for a citation of dissection opportunities as crucial to the quality of medical education at AIIMS.

of Western science and literature through exclusively English medium curricula (Bala 2007: 72–74; Kumar 1997: 52–54).

The Native Medical Institution was closed and replaced by the Medical College in 1835.⁵⁷ The first institution in India to teach Western medicine solely in English, its mission was to teach ‘the principles and practice of the medical science in strict accordance with the mode adopted in Europe’ (Crawford 1914, 2:436, cited in Jeffery 1988: 78).⁵⁸ In an effort to stress the parity between Indian and British institutions, the Indian colleges periodically raised their entrance requirements, creating a new market for the medical schools among candidates who did not qualify for college entrance.⁵⁹ Reliable data on the precise demographics of medical students is scarce, but we know that there was a broad dominance of high-caste Hindus (although fewer Brahmins than in other sectors of higher education)⁶⁰, and that Christians (initially European and later Eurasian or Anglo-Indian) were disproportionately represented, along with Parsis in Bombay. Muslims only began to be proportionately represented as a consequence of the introduction of reserved seats in the 1920s and 1930s (Jeffery 1988: 84).

The bureaucratic consolidation of Western medicine’s supremacy over indigenous practice stretched into the twentieth century: by the 1920s, medical education ‘was caught between conflicting pressures of nationalism and a swiftly changing, increasingly scientized European medicine’ (Jeffery 1988: 76). The Medical Registration Acts and Medical Degrees Act passed between 1912–1919 had excluded indigenous practitioners from claiming the title of ‘Doctor’. However, the 1919 Montagu-Chelmsford reforms allowed Indian nationalist

⁵⁷ Medical classes also ceased at the Madrasa and the Sanskrit College. In reaction to the former, over 8000 Muslims signed a petition accusing the government of ‘causing the science of Arabia to cease’ (Kumar 1997: 63).

⁵⁸ Vernacular education was reintroduced at certain institutions (although not the teaching of indigenous medicine), but was steadily transferred from the major medical colleges to peripheral schools in order to ensure good favour with the medical authorities in Britain (see Kumar 1997: 133–136).

⁵⁹ A contemporary parallel here, too, albeit on a much larger scale, as proliferating private colleges offer an alternative for students not admitted to the top tier public institutions.

⁶⁰ See Bala (2007: 30) on the historical association of medicine with impure practice unbefitting Brahmins.

politicians to implement policies despite the opposition of British medical advisors, and the Indian National Congress began to pass resolutions in support of indigenous medicine. The two positions were never fully reconciled within the party: self-proclaimed modernizers such as Nehru supported the expansion of Western (or ‘modern’) medicine, while the new regional legislative councils supported indigenous medicine on nationalist and economic grounds.⁶¹

Ayurvedic hospitals and teaching colleges were established, but their supporters faced opposition from the IMS together with the British Medical Association and the GMC. The latter made it clear that Indian medical degrees would only receive international recognition if there was a clear distinction between those trained in Western medicine and those who had studied indigenous systems. Initial support within the Indian Medical Association for the inclusion of indigenous practitioners was withdrawn and a separate register for indigenous doctors was established in 1938 (*ibid.*: 53–55).

The numbers of medical colleges, schools, and students grew hesitantly during the nineteenth century, although Jeffery suggests that figures for those who passed the final exams belie the broader impact of medical education. For example, of 2,511 students enrolled at the six medical colleges⁶² in 1916–17, only 512 sat the final exams, and of them 329 passed (1988: table 8). There were plentiful opportunities for students who left the colleges without a formal qualification to enter private practice or to take up appointments in the princely states, however, given the absence of a regulated medical market – a situation we see spectacularly magnified in today’s India, with complex consequences (Patel et al. 2015; Phadke 2016; see chapter 1). This was a somewhat paradoxical outcome for the colonial government from a functional perspective, but the nineteenth-century drive to disseminate the scientific bounty of the Enlightenment among colonized populations was never fully separable from the economic motivations of colonialism. This is confirmed in the following

⁶¹ In later years Nehru seemed more concerned to recognise the achievements of India’s own medical traditions, and he suggested in his convocation address to AIIMS graduates in 1964 that the Institute work to ‘bridge the gap’ between the two traditions (in Singh 1988: 264–266).

⁶² Calcutta, Bombay, Madras, Lahore, Allahabad, and Delhi.

explanation of British policies of nineteenth-century medical education in India:

The object [of medical education] was not merely to secure a constant supply of subordinate medical officers for the Government service but also to raise the standard of medical knowledge and encourage the practice of medicine and surgery on established scientific principles. That private practitioners possessing the necessary qualifications should be able to compete successfully with public medical charities, is a satisfactory result.

(Bengal Administration Report 1885: 306–307, cited in Jeffery 1988: 83).

Objections became more vocal, however, when the private practice of IMS members was also threatened by Indian doctors; in response, the IMS determinedly prevented Indian doctors from attaining prestigious positions as attending doctors at major hospitals.

The grip of the IMS tightened in the early twentieth-century, as the GMC began to scrutinize Indian medical education more closely; in 1930, the GMC withdrew recognition of Indian degrees until an Indian medical council was established. As Jeffery puts it, ‘the rhetoric was that Indian graduates who wished to practise in Britain should meet British standards, but the implications were to affect the patterns of medical education in and for India thereafter’ (1988: 33). The truth of this is evident in the story of AIIMS, as I show below, whose planners attempted to establish an institution that would demonstrate a universal scientific prowess, inescapably defined in and through ‘imperial knowledge’ (Prakash 1999: 71), while responding to the specific needs of the newly independent Indian nation.

When the Medical Council of India was established in 1933, the medical schools were excluded from its terms, triggering an effort to dismantle India’s ‘two-tier’ system of medical education. Where possible, schools were to be upgraded to colleges, and otherwise closed. The policy received wide support: school-educated doctors hoped to receive the benefits of college graduates; British members of the IMS hoped it would end London’s concerns about Indian standards of education; and nationalists were uncomfortable with the notion that medical schools implied

second-class care and prompted international mistrust of Indian qualifications.⁶³ By 1938, the decision was taken to close the medical schools (Jeffery: 86).

The Bhore Committee

In part an effort to assuage the Indian elite through a demonstration of concern for 'national welfare' in the wake of the recently launched Quit India movement, but also presaging a broader post-war shift in the West from laissez-faire to greater state interventionism,⁶⁴ The Health Survey and Development Committee was appointed by Viceroy Mountbatten in October 1943 (Amrith 2006: 57). Subsequently known as the Bhore Committee after its Chairman Sir Joseph Bhore, a senior civil servant, its task was twofold: to conduct a 'broad survey of the present position in regard to health conditions and health organisation in British India', and to provide 'recommendations for future developments' (GoI 1946, Vol 1: 1).

The four-volume 'Bhore Report' presented in 1946 is implicitly critical of the colonial neglect of Indian public health, and of the defeatist attitude of the contemporary civil service in the face of a task of such magnitude. The report is also unequivocal that health is a right, the protection of which is the responsibility of the state. It expresses a perhaps unexpected zeal for the cause of universal free healthcare as a means to national (and international) human uplift, for the necessity of understanding the social determinants of health, and a frustration with the folly of divorcing health from economic concerns (Amrith 2006; Bajpai & Saraya 2011; Jeffery 1988: 112).⁶⁵ Promoting the dovetailing of preventive and curative care, the report's recommendations encompass medical care, education, and administration, with specific attention to industrial, maternal and child health, and nutrition.

⁶³ As Jeffery notes, such debates would resurface post-independence. They remain very real in conversations about establishing shorter training courses for paramedical staff, or for informal practitioners with no official qualifications (Das 2016, for example).

⁶⁴ Exemplified in Britain by the Beveridge Report of 1942, which presaged the creation of the National Health Service.

⁶⁵ The Committee members were largely civil servants and private medical practitioners on whom the Viceroy felt able to rely. Murthy et al. suggest that a group of international advisers invited to India in 1944 may have influenced the more radical moments of the report (2013: 76), as they did the early plans for AIIMS.

Although not without dispute, The Bhore Report endorsed the policy that saw the closure or upgrade of medical schools (Jeffery 1988: 243). While a minority of members argued for the rapid expansion of all levels of medical education, the report ultimately recommended that India should focus its limited resources on training only ‘the highly trained type of physician whom we have termed the “basic doctor”’ (GoI 1946, Vol IV: 60). The decision to marginalize education for paramedical or auxiliary personnel has had enduring consequences in the debate about whether and how to utilize India’s vast number of informal practitioners in the effort to improve public healthcare, particularly in rural areas (Das 2016).

Despite its colonial inception, the report’s recommendations were accepted in principle by Congress leaders not least for the explicit articulation of the economic imperatives of comprehensive attention to public health, and the way in which ‘the Bhore Committee tied their plans for health closely to the legitimating language of planned development’ (Amrith 2006: 63). Nehru seemed to have taken particular notice of the stress on public health policies over individual curative treatment. In his inaugural address to the Health Ministers Conference in 1950, he emphasized the importance of paying attention to food security and adequate housing as a means to ensuring basic standards of public health. He acknowledged the challenge of cross-sectoral thinking about health policy (a challenge that persists today), but urged the ministers present to ‘lay greater stress on the prevention of disease and on the general raising of public standards of health than on individual treatment’ (GoI 1954: 552).

Nevertheless, neither the Bhore Committee’s broader ten-year or forty-year recommended plans were brought to fruition. Some analysts argue that the consequences of this failure to implement the recommendations are clearly visible in contemporary India’s landscape of inadequate public healthcare⁶⁶ (Dreze & Sen 2013; and see chapter 1).

⁶⁶ The Bhore Report has also attracted recent scholarly attention for its parallels with, and implications for, the contemporary debate about universal healthcare and the right to health in India, and to a lesser extent the National Rural Health Mission (Bajpai & Saraya 2011; Murthy et al. 2013).

‘An Indian institute established in India, for the training of Indian workers by Indians’

In 1943, the year of the Bhole Committee’s appointment, the colonial government invited Professor A.V. Hill, Secretary of the Royal Society in London, and a deputation⁶⁷, to visit India and ‘advise it on the future of scientific research in the context of development’ (Madan 1980: 30). Their report focused on education:

For the most effective way of producing a change in all this would be to set out deliberately to create teachers and research workers of a new kind, people who would devote their lives to the single object of advancing in India the art, science and practice of medicine. For this purpose a great All-India Medical Centre should be established, an ‘Indian Johns Hopkins’ staffed in all departments by the ablest people available anywhere, employed full-time and adequately paid. The students of the All-India Medical Centre should be highly selected ones, preferably with good degrees in arts or science as a start: and since a large proportion of the most desirable students cannot meet the financial cost of a long training in medicine, all who require help should be given it in the form of scholarships or bursaries ...

... The intention of the All-India Medical Centre would be to produce the future leaders of Indian medicine and public health, the teachers and research workers ...

... If the All-India Medical Centre is to play the national part it should in advancing medicine and public health, and to gain the international repute which will put Indian medicine ‘on the map’ and attract first-class teachers and research workers from any part of the world, then I think it must be given the national recognition and status which is possible only by its establishment at the Capital of India.

(Hill 1945: 10–11, cited in Madan 1980: 30–31)

During the visit, Hill ‘had detailed discussions with the Bhole Committee on the question of the proposed institute’, and for a brief period the plan for an institute was known as ‘Prof. Hill’s scheme’ (Pandit 1982: 147). Two years later, the Bhole

⁶⁷ Key figures included Henry Sigerist, the communist historian of medicine at Johns Hopkins University; Janet Vaughan, Principal of Somerville College, Oxford, who ran the first blood bank in London during the Blitz and was one of the first people to explore the association between illness and poverty; and John Ryle, the Oxford pioneer of social medicine (Murthy et al. 2013: 76).

Report included the recommendation that an All-India Medical Institute be established:

The objects of the Institute should be 1) to bring together in one place educational facilities of the very highest order for the training of all the more important types of health personnel and to emphasize the close interrelation which exists between the different branches of professional education in the field of health; 2) to promote research of the highest type...; 3) to co-ordinate training and research; 4) to provide postgraduate training of an advanced character in an atmosphere which will foster the true scientific outlook and a spirit of initiative; 5) to inspire all persons who undergo training, undergraduate or postgraduate, with the high ideals of the profession to which they belong and 6) to promote in them a community outlook and a high degree of culture, in order that they may become active apostles of the progressive spirit in whatever field they may be called upon to serve ... *Though the alumni of such an Institute may not be numerous, we feel confident that the influence which they will exert in their respective spheres will be out of all proportion to their numbers.* (GoI 1946: Vol IV: 70, my emphasis)

Following the submission of Hill's report in 1945, Dr C.G. Pandit, a London-trained virologist who was director of the King Institute of Preventive Medicine and Research in Madras, was deputed to accompany Sir Bennet Hance, Director-General of the IMS, on a research trip to the UK, US, and Canada 'to study and report on the modern trends in medical education and research' with a particular impetus placed on Johns Hopkins, Hill's suggested model for an All India Medical Centre (Pandit 1982: 147). The terms of reference included the following:

Enquiries should be directed primarily towards securing information which would be of value in the preparations of plans for the organisation of a medical training and research centre, the purpose of which will be to train men, who will eventually be leaders of the medical profession, especially teachers and research workers. *It should be borne in mind that the primary object of such an institution will not be advancement of scientific knowledge, but the training of students.* (Ibid.: 157, my emphasis)

The deputation received an enthusiastic response when it presented ideas for the institute at Johns Hopkins:

Several of them...expressed the opinion that such an Institute, in addition to making the most effective possible contribution to India's needs, would be the most complete and effective yet achieved, and, if the experiment proved successful, would eventually attract students and research workers from all over the world. (Ibid.: 159)

The Goodenough Committee in Britain had recently released a report recommending 'the reorganization of medical education and research' (ibid.: 158), and the wartime deputation stated in its own report that 'throughout the English speaking world a great renaissance in health provision and education is in formulation and the end of hostilities will see a burst of progress in matter (*sic*) of health unprecedented in history' (ibid.). This reforming enthusiasm permeated discussions, particularly at the University of Oxford, which was developing its own plans for an undergraduate medical school that would adopt innovative teaching arrangements.⁶⁸

Following consultations with the medical faculty of Liverpool University, Professor R.A. Morlan sent a letter to the committee urging that the specificities of India be given as much consideration as international models in establishing the new institute:

In both teaching and research, it could be held that relevance to India should decide priorities. I do not mean simply utility but relevance in [a] wider sense ... The whole problem of geography in relation to disease affords an instance of a long term programme of research to which individuals could contribute and the institute could act as the unifying agency and building up its own peculiar prestige, team spirit and continuity ... One would think that medical anthropology could be cultivated in India as nowhere else. Similarly the problem of 'putting over' preventive medicine affects all the world but India affords a unique laboratory for research in the borderland between education and medicine. I hope this makes clear what I mean by relevance as a strategic aim. The Institute should be *itself*, an Indian (*sic*), not a transplanted Johns Hopkins or Mount Vernon. (Ibid., original emphasis)

⁶⁸ These were particularly promoted by Professor J.A. Ryle, head of the Department of Preventive and Social Medicine, and a pioneer in the field. He described to the committee his method of teaching beyond lectures, including interactive seminars at which patients were present. 'The idea that the disease is a social and economic problem is inculcated,' he told the visitors (Pandit 1982: 161).

On returning to India, Pandit was tasked with writing up the committee's report. He concluded by stating that: 'Another essential feature of the proposed Institute is that it should eventually become an Indian institute established in India, for the training of Indian workers by Indians' (ibid.: 164).

This report fed into the work of the Bhore Committee, whose own report in 1946 led to the establishment of a committee tasked with implementing the AIIMS project. According to Pandit, the plan was shelved for some time due to financial constraints – 'as an interim measure a decision was taken to upgrade certain departments in medical colleges, where suitable leadership was available' (ibid.: 165). Nevertheless, the newly independent Indian government recorded its intention to establish the recommended institution in its first five-year plan (1951–56), and the project was revived by the allocation of a \$1.25 million grant by the Government of New Zealand under the auspices of the Colombo Plan.⁶⁹ The foundation stone of the 'All India Medical Institute' was laid by New Zealand's minister of industries and commerce in 1952.

Reflecting the abiding concern to establish an institution not only pre-eminent within India but on par with similar colleges in the West, K.C.K.E. Raja, Secretary of the All India Medical Institute Committee, set-off in 1952 on a research mission to the US, UK, Canada, Sweden and Switzerland, 'to familiarize himself with the working of medical educational and research institutions in these countries and to establish the necessary contacts for the possible recruitment of overseas staff' (Madan 1980: 33).

In the contemporary re-telling of the AIIMS origin story, the civil servants are largely erased – other than Joseph Bhore by virtue of the eponymous report – or at least dramatically overshadowed by the influence of Nehru and Rajkumari Amrit Kaur, the political celebrities with the power to command the institution into existence. 'I think we have to be eternally grateful to Rajkumari Amrit Kaur,' Dr E told me. Having been a secretary to Gandhi in the 1940s, and founder of the All India Women's Conference, her subsequent position as independent India's

⁶⁹ International assistance also came from the United States Technical Collaboration Mission in 1960 for construction of the main hospital, and from the Rockefeller Foundation for the purchase of medical equipment and library resources (Madan 1980: 36). Nehru acknowledged this assistance in his convocation address in 1964.

first health minister ensured that she was crucial to the implementation of AIIMS. She 'handpicked the faculty', Dr E said, and donated a family home in Shimla to the institute, which remains a faculty guesthouse. Kaur, Nehru, and B.B. Dikshit, the first director of AIIMS, were referred to as 'the troika', he said. Dr E also brought the nationalist politician and doctor B.C. Roy into the foundation picture and described a scene at a diplomatic reception at which Roy suggested the idea of AIIMS to Nehru and Kaur. The pair was enthusiastic but stressed a lack of resources, at which the New Zealand High Commissioner is said to have volunteered the funds. Whether or not this latter tale is apocryphal, the long-planned All India Institute of Medical Sciences⁷⁰ opened its gates in 1956.⁷¹

Recollections of the beginning (2) – Dr T

I grew up in a place called Agra. So in Agra, I went up till 7th standard. After that I came to Delhi because my parents were here in Delhi. So I did my schooling and all that... In those days we used to have two classes, higher secondary and pre-medical. Higher secondary was 11th grade, pre-medical was 12th. So I did my 11th and 12th, in both these I got first division. In those days, getting a first division, that means above 60-65%, meant you were the king! And I did that.

My maternal grandfather was a doctor, in Agra. And he had such a terrific name. He was a teacher in Agra Medical College and he used to practise also. Since I was living there, I used to see people coming to him, and him practising and all that. And they used to tell him, 'We have no money to pay you', and my grandfather used to say, 'OK, go away! No problem'. So that's how I saw medicine from a very close quarter as a child. And it was quite stimulating.

In those days Delhi did not have a medical college. So they used to nominate five students from Delhi to different institutions in India. So I got that. I got admission in Gwalior. Agra was my domicile, so I appeared there also, and got through, so I got admission in Agra also. Finally, AIIMS, the result came in the last. And I must say there was a health ministry official who was somewhat related to us, to my father. And he told me, 'what are you doing, this is going to be the biggest institution in the country and you are thinking of Agra and Gwalior and all that, this is rubbish. You wait for the result, All India Institute, and if you get through, fine'. So that's how it is. So I got through there – All India Institute. My mother was the inspiration. She wanted me to be...we had two uncles who were doctors. So that is how I got into medicine, grateful to my mother.

⁷⁰ It is not clear when the name was adapted to include 'medical sciences', but the change is worth noting.

⁷¹ The Institute was officially opened by the British monarch Elizabeth II, in January 1961. In October 2016, during an exhibition to celebrate the AIIMS diamond jubilee, it was announced that the tree planted by the queen had succumbed to termites (Business Standard 2016b).

I spent 47 years of my life there. It's more than half my life I suppose. So...that is how it was. And I saw AIIMS being built brick by brick. The hospital came up in 1965; there was a gap. And during that gap we used to go for our clinical training to Safdarjung Hospital, for medicine, for surgery, for orthopaedics. That was an interesting period because Safdarjung Hospital is a busy hospital, with lots of clinical material and we used to see that. I finished my MBBS in 1962, did my house-job. My first house-job was cardiothoracic surgery. And second house-job was orthopaedics. My boss asked me, 'What would you like to be, would you take up orthopaedics?' I said no. He said, why not? I was very thin actually, and I said, sir, orthopaedics requires lot of brawn, pushing and pulling, I can't do that! And therefore I don't like orthopaedics; I'll probably take general surgery. He had worked in Britain for 40 years, so his accent was British: 'You are a bloody fool!'

Before I became a director, I asked one of my friends, he was a classmate from Agra and was practicing in Moradabad. So I asked him, suppose I want to take up [private] practice; my name is being considered for directorship. You know the reply he gave me? 'Never ever think of going for practice if you are getting the directorship. There is nothing like...it's the most prestigious medical thing for you. So you become a director.'

Nehru, and the science of development

The emergence and existence of India is inseparable from the authority of science and its functioning as the name for freedom and enlightenment, power and progress. (Prakash 1999: 3)

The intention to place science and technology at the service of national 'development'⁷² is embodied by the AIIMS foundation stone. As is an idea of the 'postcolonial' as more than a simple 'celebration of the end of colonialism' (Anderson 2002: 643). Rather, as Anderson notes, 'it signals a critical engagement with the present effects – intellectual and social – of centuries of "European expansion" on former colonies and on their colonizers' (ibid.: 644).

David Arnold (2013) expands as follows with specific reference to India:⁷³

⁷² The politics of knowledge in colonial India as expressed through science and technology has been well documented by historians (see Raina & Habib 2007 for an overview). The postcolonial context has also been analyzed by social scientists, including those who have critiqued the limitations of science as part of the Indian development project, arguing that the epistemic violence of its imperial heritage makes it inherently oppressive (Prakash 1999; Ravi Rajan 2005; Phalkey 2013).

⁷³ See Anderson and Pols (2012) on examples of 'scientific patriotism' wherein the nationalist movements in several Southeast Asian colonies were dominated by men trained in science and medicine. India's independence movement, by contrast, was dominated by lawyers.

Postcolonial science might be presented as literally that: as sited temporally after colonialism. But India's independence was long anticipated and its science had by the 1930s reached a point of maturity—in institution building, individual achievement, and international recognition—that encouraged high expectations of what would happen once colonial constraints were removed. [Nehruvian science] began its 'postcolonial' career more than a decade before independence in 1947, just as it continued long after that date to grapple with the legacies of colonial rule and its continuing manifestations. (364)

We have seen that AIIMS was initially conceived in a report commissioned by the colonial administration. That it was finally built and inaugurated under the auspices of an Indian government, with international funding, suggests less an epistemic break in scientific discourse, then, than an opportunity for a potent new narrative that blended the challenges that faced the new nation with the promise of scientific remedy.

Jahnavi Phalkey refers to this developmental discourse as 'Nehruvian optimism' (2013: 331). While, as Arnold notes, it is necessary to be cautious about 'exaggerating the contribution of one individual or of shrinking the temporality of postcolonialism to fit the compass of a single life' (2013: 361), the personal involvement of Jawaharlal Nehru in the AIIMS project warrants attention to Arnold's interrogation of the 'Nehruvian science' (NS) that was so influential in the early life of independent India.

Nehru's understanding of science as not only technical, but 'also a philosophical and literary pursuit', Arnold suggests, informed his determination to confirm 'the centrality of science in the autobiography of the Indian nation' (ibid.). This had motivations beyond the poetic:

...since science stood for authority and a higher form of knowledge, NS sought to contest Western presumptions of a monopoly over science... while extolling the transnational foundations of modern science, Nehru understood science, intellectually and functionally, primarily in relation to India's national needs and Cold War ambitions. NS presented science as a program of delivery, committed to redressing such basic social problems as ill health and poverty, an endeavor answerable to the state and the public it aspired to represent. (Ibid.)

AIIMS represented all of these things, but arguably stood above all else as a symbol of the new government's determined march towards an internationally approved standard of modernity as represented by science (Prakash 1999). When A.L. Mudaliar, chair of the AIIMS planning committee, spoke at the first meeting of the Central Council of Health in 1953, he argued that undergraduate education at AIIMS should be 'along the most modern lines that are accepted in international circles' and that:

It is very important for us to realise that we must look to international standards ... When it comes to a question of helping in the cure of the sick and the general welfare of the community you cannot afford to forget international standards or lower your standards below the international level. If you do that, you will be the worse for it. (GoI [CCH] 1954, cited in Jeffery 1988: 244-45)

In his study during the 1970s, Madan found that AIIMS faculty compared themselves with their counterparts 'in the advanced Western countries' (1980: 62). Some of his respondents thought this was detrimental and had created 'both a dependence on the ideas, concepts and techniques of Western doctors and an alienation from the problems and resources of the country' (ibid.; see chapters 7 & 8 of this thesis). By the 1970s, research was already subordinated to the heavy burden of patient care at AIIMS (ibid.: 77). This dual dynamic of comparison with the West and the frustration of having insufficient time for research persists, according to Dr J, who joined the Institute as a postgraduate student in 1969. 'Compared to our counterparts in the West – because the AIIMS faculty has always been competing with the West – compared to them we people get very little time for research,' he told me.

This preoccupation with universalist standards of science and their application to national imperatives was expressed most explicitly through Health Minister Rajkumari Amrit Kaur's speech when she presented the All India Institute of Medical Sciences Act⁷⁴ to Parliament on the 18th of February 1956. The speech

⁷⁴ See <http://www.aiims.edu/aiims/ritact/AIIMS-ACT-RULES.pdf> [accessed 18/4/16]

highlights all that was intended to be unique about AIIMS, but also contains arguably insurmountable contradictions of purpose that, as I will suggest, have had consequences for medical practice within and without the Institute.

Towards the beginning of the speech, Kaur asserts that:

Medical education must, above all, take into account the special needs of the country from the point of view of affording health protection to the people...the continued prevalence of various forms of preventable causes of sickness and suffering necessitates special emphases, if I may so put it, on the preventive aspect of medical care. Further the extent to which [a doctor] develops a community outlook and a desire to serve the people. Medical education, moreover, is receiving considerable attention in all the progressive countries of the world. I have had the privilege recently to see what is being done in the U.S.A., in the USSR, in Scandinavia and even in the U.K...to bring it more and more into consonance with present day needs and to promote an increasing realization of the object of equipping the future doctor to give of his best to the community. India cannot afford to keep apart from this broad and steady programme of development that is taking place in other parts of the world. (1956: 1)

Shortly afterwards, Kaur notes that the Institute was:

...going to start with a medical training centre which will provide undergraduate study to only a very very limited few. *The major emphasis will be on post-graduate study and specialization*, because one reason for our inability to fulfil the desire of so many States today to have medical colleges is the lack of personnel. (Ibid., my emphasis)

The speech goes on to note the special measure of prohibiting private practice by AIIMS doctors and compensating them with higher salaries to ensure their exclusive focus on the Institute, and the importance of a residential campus to ensure a personal *guru-shishya*, or teacher-student, relationship, in the spirit of one Indian tradition of education. Students should be given ‘ample opportunities to participate in both urban and rural health work,’ and the curriculum should encourage ‘a community outlook and also promote powers of initiative and observation and of drawing conclusions from them.’ The Institute would be ‘given the powers and functions of a University because it will probably make

revolutionary changes, as I hope, in curriculum as well as in modes of teaching,' and would 'enjoy a large measure of autonomy in order that it may fulfil the objectives'. While the government would provide the primary funding for the maintenance of the Institute, Kaur hoped that 'philanthropy also will come to the aid, as it so often does, of such institutions because, after all, serving the cause of sick and suffering humanity is always something that appeals to those who would like to give.'⁷⁵

In conclusion, the speech stresses that the future of the Institute lies in the hands of its members:

I believe it will be their devotion to duty, their desire to promote their work and the spirit of altruism that will actuate them to subordinate personal considerations, as I believe the noble profession of medicine should do, to the fulfilment of the objectives to be achieved that will eventually create and maintain the atmosphere which is necessary for an Institute like this. I therefore do hope that in presenting this Bill for acceptance by Parliament today, the legal structure that is created may facilitate the medical education in the Institute and that, through the influence it exerts, the standards of different forms of professional training in the field of health throughout the country will be raised. (Ibid.: 3)

The ambition articulated for the new institution was formidable⁷⁶. AIIMS was intended to change the face of medical education and practice in the nation, while deliberately catering to a small number of students to ensure a unique pedagogical experience; students were to develop a community outlook, a commitment to national service in both rural and urban settings, to develop (in an echo of the Bhole Report) a preventive orientation, to emulate Western 'progress' while responding to Indian needs, while the greater purpose was to focus on postgraduate specialization and the training of teachers. In 1973's *Medicine and Society*, Henry Miller writes that:

⁷⁵ In fact, a philanthropic tradition never developed at AIIMS, unlike at the Indian Institutes of Technology (IITs) established in the 1950s and propelled by a similar impulse (see chapter 6).

⁷⁶ The AIIMS Act retains a provision in Article 14 to 'provide for the teaching of humanities in the undergraduate courses'. This inclusion might have been encouraged by the advocates of comprehensive social medicine teaching, but there is no evidence to suggest such courses ever took place at AIIMS (also see Madan 1980: 82–83).

...the Indian predicament is characteristic and understandable. Unless the government trains a medical *corps d'elite* it will be unable to undertake the practical research into preventive medicine that is central to the Indian situation. Furthermore, it will demoralize the medical profession to whom involvement in high technology is a matter of national pride, even if it is not always so easy to justify on utilitarian grounds. (81)

There is an infectious energy (and a retrospective romance alluded to by students and faculty of that time) in the national ambitions articulated through AIIMS, as also an almost poignant recognition of the scale of the challenge expected to be met by an institution without sufficient supporting primary and secondary infrastructure to protect its tertiary mandate, or to ensure that the students it produced were willing and able to establish careers at home rather than leaving the country, as so many of them did.

By 1956, the first year of AIIMS, Arnold notes that 'technology' was being promoted over 'science' in Nehru's speeches: 'Thus in 1956 he spoke of "the stupendous growth of technology" and the need to think "in technological terms" of the requirements of the planning process' (2013: 366). Great energy went into the establishment of the Indian Institutes of Technology in the 1950s, a set of institutions that, in a broader sense than AIIMS, were expected to produce graduates who would shape the future of the country:

Now you are engineers and this world today becomes more and more, shall I say, it takes shape more and more under the hands of engineers. There was a time when administrators played the primary role in the country's government and development. ... But the time has now come when the engineer plays an infinitely greater role than anybody else. ... We are building up a new India and the administrator who is completely ignorant of engineering does not help much in administering. He cannot understand this new domain. You will find in a country technologically developed, how engineers and scientists play a far more important role even outside their sphere of engineering and science. That is right and that is bound to happen in India. (Nehru, convocation address at IIT Kharagpur, 1956)⁷⁷.

⁷⁷ <http://www.scholarsavenue.org/news/convocation-address-by-shri-jawaharlal-nehru-at-the-first-annual-convocation-held-on-21st-april-1956/> [accessed 22/4/16].

Arnold suggests that ‘medicine and public health never stood quite so high in Nehru’s esteem’ (2013: 366) as more explicitly technological pursuits. Reading the speeches that Arnold cites, however, I am struck less by a lack of esteem for medicine and public health than by Nehru’s grappling with two separate but related challenges. Firstly, that technology did not offer and could not be considered a single magic bullet for public health; and secondly, how to reconcile a principle of quality over quantity in medical education with the glaring need for a very large number of trained healthcare professionals. These tensions, I suggest, have always been, and remain, intrinsic to AIIMS.

Despite Nehru’s commitment to technology as a tool of national development, in the 1950s he was well aware of the pitfalls of adhering to high technology alone as a public health solution and he foresaw the detrimental consequences of a singular focus on individualized, curative, and largely urban, medicine. However, it is also clear in his address to the silver jubilee celebrations of the Medical Council of India in 1959, that while he was unhappy about the lack of progress in providing comprehensive healthcare beyond the cities, he did not consider this the sole responsibility of central government:

Now, in spite of 25 years of the All India Medical Council, India is still very poor in the quality of its doctors. In reality and in effect there are vast areas of India where there is practically no medical help available...I do not quite know if you have given thought to this matter. It should be the function of the Medical Council to make suggestions or lay down some rules and regulations even, that it should be incumbent on every new practitioner before he can even practise anywhere to spend a couple of years in a village or in some rural area...It would be a good thing if the Medical Council itself went into this question and laid down some kind of a rule or regulation rather than for Government and Parliament to come in and do something of the kind. (In Singh 1988: 193)

Whether or not it was the lingering influence of the Bhore Report, or a result of Nehru’s own observations, or both, he maintained his conviction that social and preventive medicine should take priority, even as he watched the opposite trend become entrenched:

The actual day-to-day work of a doctor should become more and more preventive than actual treatment, although the latter is of importance. We put up big hospitals and that is inevitable. You must have some big hospitals where there is a concentration of work, but one cannot put up these big hospitals all over India, or even smaller hospitals but rather on a large scale. We should evolve some way of giving medical services to the villagers, because I am constantly thinking as to how to deal with them. (In Singh 1988: 194)

Arnold's analysis bears greater weight in the sense that while the prime minister had strong convictions about health and medicine, he did not afford them his direct oversight – unlike the Department of Atomic Energy, for example, of which he retained personal control (2013: 367). This is arguably also suggested by the abstract language of hope germane to Nehru's speeches about health and medical policy.

I should like you think of these problems which are really vital problems for us, in a sense more vital than the individual big problems of big hospitals and all that you have to deal with. Ultimately, I hope that there would be free medical services for anyone who requires it in India, and high standards of public health. (Ibid.: 195)

Fifteen years later, at the second convocation of AIIMS in 1964, Nehru articulated similar preoccupations, with quantity versus quality, technologized medicine versus preventive public healthcare, urban versus rural practice, and here he also dwelt on his concern that India's tradition of indigenous medicine and learning should not be forgotten. In comparison with the rousing call to arms Nehru delivered to the graduates of IIT Kharagpur in 1951, however, his AIIMS address was notably sober, almost weary perhaps, as he confronted the challenges that the country still faced in its effort to improve the health of its people. He noted with approval the study of preventive and social medicine at AIIMS and stated that he considered it 'particularly important in the modern age' (Singh 1988: 265). The subject should be, Nehru said, 'the dominant function of the Institute and the people who go out of this Institute, because social medicine prevents those things happening which require treatment later

on. I hope enough attention will be paid to the social aspects of medicine' (ibid.).

This challenge echoes the parliamentary speech of Rajkumari Amrit Kaur, discussed above, wherein the AIIMS mandate was to be at once an exclusive centre of cutting-edge research and technology, and an incubator of doctors who would take social and preventive medicine to the rest of India. Nehru's convocation speech took place a month after the death of Amrit Kaur, and he lamented her absence: 'In my mind this Institute is so intimately connected with her that I can hardly think of one without the other. Right from the beginning of this Institute she was constantly discussing [it] with me and whenever any kind of difficulty arose, she came to me' (in Singh 1988: 264). 'It is comforting,' he went on, 'to find that your Institute has not so much cared for quantity as for quality. It is essential that we should have higher standards at the top as these will determined the quality of work below to a large extent' (ibid.). Having discussed the need for rural doctors, he then goes on to admit the overwhelming scale of the challenge and his own uncertainty about the remedy:

One thing that troubles me is that in spite of such fine institutes as this one, yet there are vast areas in this country...where the benefits of modern medicine do not reach and sometimes we are rather overwhelmed by the problem. So many people are wanted there – qualified physicians, surgeons and properly equipped institutions – and we have so few. It is obvious that, however good an institute like this may be, that is essential of course; one can only be satisfied if it reaches down to the villages and if thousands, hundreds of thousands of villages feel the impact of it. I do not know how we are going to train the people in such large numbers to go there; and I will suggest to you, those who are trained, have received the benefit of training at these special institutes, should always bear in mind the need of the people of India who live in the villages. Because they are in numbers as well as otherwise the real people of India and unless we know them, we do not function properly. And then how to deal with such vast numbers and how long it will take enough people to go there, is a difficult matter. Whether it is conceivable to have institutes at these villages, some kind of assistance to serve the community, bring up the real cases to experts or how to deal with it, I do not know. But something has to be done to bring modern medicine to the great majority of our people in the country. (Ibid.: 265)

There is a retrospective poignancy to these words of an increasingly frail statesman, who once regularly noted the robustness of his health and the rarity with which he consulted doctors, but who could not offer answers to the questions of illness and death that afflicted so much of the population, beyond vaguely articulated hopes. Within two months of his address at AIIMS, Nehru himself would die at the age of 74.

Recollections of the beginning (3) – Dr V

I joined AIIMS in 1960. 1959 the hospital was started, so amongst the clinical faculty I would be amongst the early ones who joined. You see at that point in time, it was Rajkumari and Pandit Nehru. She would pick up the phone and say I want this, and he would say all right, you will have it. There was no bureaucracy in between. I can give my own example. I was working at Lady Hardinge Medical College; when the AIIMS advertisement for faculty came, I was selected. Normal course of events. And when I had to leave Hardinge to join AIIMS, the principal at Hardinge said, I can't relieve you, I have no one else. But I said, I am getting an opportunity, you have to relieve me. She said, whenever a substitute comes, I will relieve you. So what could I do? So I kept on getting letters from AIIMS, that when are you going to join, when are you going to join, and I would write back saying at present I am at Lady Hardinge Medical College and I cannot leave till I get permission to leave and I am not getting permission till a substitute comes. So I get another letter saying if you do not join by this date, it will be assumed that you are not interested in joining. Now what could I do? I was in a dilemma. So I looked around; how can I go and meet Rajkumari Amrit Kaur and sort of explain my dilemma to her? There was no other way I could handle this situation. So then I found a friend who knew Rajkumari Amrit Kaur and he rang her up and said I have a damsel in distress ... he told her [of the situation]. So Rajkumari said to me, look I cannot let you go away from Hardinge till someone else comes. But I can tell the director at AIIMS that you will join as soon as, and not to send these letters to you because you are selected. So this would normally bypass normal rules. Because she intervened, and she could dictate, that it's a new institution, and you can bypass these rules. But [without the intervention], I would have never joined AIIMS.

...the best thing that the founders of AIIMS did was they built houses on the campus. So everyone was available on the premises when the hospital came up...so that you have the full attention of the faculty to deliver services and to teach. And it was thought that if you have only 50 students then you can experiment on methods of teaching, whereas in the larger medical schools you have 100 students, 150 students, that's too big a number to be able experiment on teaching modules. That was the idea. But unfortunately that never happened. Because one was not able to create models, because we never built an area where you could invite people who could stay there and teach. You see? We had to

provide for people who would come in, we would train them and they could go back to the states and teach. That model was not prepared. Therefore models of education were really not set by AIIMS. But they acted as role models to the 50 students that came in.

It didn't take more than five years to establish itself... And soon the country knew that you are running an institution which was different. Right? Now where did we go wrong is what I would like to tell you. AIIMS as I said was created to be a centre for teaching. Right? But I can't say AIIMS went wrong, but where the government went wrong. They thought we created the All India Institute, we won't do anything else. You see. So the net result was that the state of Delhi, where...as the population grew, you should have created centres of healthcare, of medical education. But the government didn't do it. So the net result was that AIIMS which was a specialized sector, where the emphasis was really postgraduate education, everyone who had cough and cold and diarrhoea started coming to AIIMS. And we had no means to close our doors. So you paid for your efficiency. You should have really not have seen the primary care, secondary care, and you should have been looking at tertiary care. That is what you were created for. That is what it was for. But since the government did not create other places of healthcare, where do people go? So people said already we will lie outside the hospital till you get admission. Because government did not step in to put in healthcare on a national scale.

...in 1960, the early 60s, they envisaged that we will have 600 patients coming in a day to the OPD. By 1990s, that is 30 years, there were 3,000 people coming in, which means five times more, and today there are 10,000 every day, I'm told, coming to the OPD. Of course it was realized that we ought to do mid-course corrections. A committee was set up to look into the working of AIIMS and give mid-course corrections. And we did prepare a report for that and gave it to the government, it must be lying somewhere. We said separate out primary care, secondary care, we can't close our doors. But we can separate them out. But it wasn't done. That still can be done, if the government wants, it can be done.

In 1970, 25 years after his research expedition, C.G. Pandit was invited to the AIIMS Annual Day. 'Annual Day, to my mind, is a day of stock taking,' he says in his memoir (Pandit 1982: 167), and records that he concluded his address as follows:

When I look at this campus, with its beautiful and impressive lawns, note the sharing of the campus by the staff and students, admire the highly developed laboratories, and clinical departments, and inevitably reflect on all that you have done and achieved, I feel that you have created here an 'island of excellence'. But will it always remain a lonely island, or as some others would put it, an ivory tower? Or, on the other hand, will you be helping in making this country an archipelago with many islands of excellence in it? Excellence must not be isolated in islands but must flow

into the main stream of national life. Was that not the dream of the original planners of the Institute? (Pandit 1982: 167)⁷⁸

*

In this chapter I have sketched the historical processes that led to the establishment of AIIMS in 1956. In doing so, I have presented AIIMS as a postcolonial institution reflecting the politics of knowledge imbricated in India's transition to independence. I have also suggested that the 'dream of the original planners' that C.G. Pandit (1982) refers to above was never singular – that AIIMS became the repository of multiple aspirations and that expecting it to fulfil them all was perhaps never a realistic prospect.

I have interspersed the institution's history with first person recollections of its beginnings by two of its earliest faculty members, and an early student who went on to become a director of AIIMS. In letting these individuals speak for themselves, I have intended them to breathe life into the context explored through secondary historical material, illuminating from personal perspectives both the optimism and the challenges inherent in a nascent institution so filled with promise for the newly independent nation.

In the chapters that follow, I explore the contemporary student experience of AIIMS, illuminating the ways in which the institution is neither an island, nor constitutive of an archipelago, but more of an isthmus, connecting the complex ideals of its founders with the complex reality of education, health, and medicine in today's India.

⁷⁸ In his memoir, Pandit laments the failure of AIIMS to become 'a teacher training institute for the country as a whole' (1982: 166). He lays the blame for this partly on the rapid abolition of the IMS post-independence, which he argues undermined the centre-state cooperation necessary to the original plan for the Institute. The Mudaliar Committee, tasked in 1962 with reporting on the performance of the health sector since the Bhore Report, noted that the abolition of the IMS 'had a certain centrifugal tendency in the sphere of health administration' and recommended that an All India Health Service be established along the lines of the Indian Administrative Service (IAS). The proposal was not adopted.

CHAPTER 4. BEING THE BEST: GETTING IN

The social world is accumulated history (Bourdieu 1986: 83).

In the preceding two chapters, I explained the features that make AIIMS a unique institution in the landscape of Indian public healthcare medical education, while introducing my guiding argument that AIIMS is simultaneously insulated from, permeated by, and complicit in sociomedical realities beyond its gates. This chapter begins an analysis of student lives and education at AIIMS that continues through chapters 4, 5, and 6.

Before we walk through the Institute's gates, I begin this chapter by introducing the students who will appear in the following chapters, and their reasons for studying medicine. I then approach the AIIMS admissions process from a historical and conceptual distance, tracing the structures and processes that ultimately influence who wins a seat at the institution. I examine the steps involved – schooling, coaching, studying, and the exam itself – and suggest that historical and contemporary social influences ripple through each phase. Following several anthropologists of education, I invoke Bourdieu (1986) as a means of understanding the role of capital – social, cultural, and economic – and its reproduction in accessing and benefiting from educational opportunities.⁷⁹ As our students win their seats at AIIMS, I follow Long and Moore (2013) by characterizing this achievement as an event with its own social life and consequences, represented not least by exam rankings, the subjectivity of which I explore by positing the concept of a 'biographical number'.

⁷⁹ Bourdieu presents 'three fundamental guises' of capital. The first is economic, 'which is immediately and directly convertible into money and may be institutionalised in the form of property rights' (1986: 84). The second is cultural, 'which is convertible, on certain conditions, into economic capital and may be institutionalised in the form of educational qualifications' (ibid.). And the third is social, 'made up of social obligations ("connections"), which is convertible, in certain conditions, into economic capital and may be institutionalised in the form of a title of nobility' (ibid). Crucial to this theory is the convertibility of the different forms of capital and the labour inherent in this process. Bourdieu was particularly concerned with how educational systems act to reproduce social structures, and it is from this perspective that we will encounter his thoughts in this chapter (see also Bourdieu & Passeron 2015).

Why medicine?

Before following some applicants on their journey into AIIMS, I pause here to ask why our students chose to study medicine – retreating in time and space to glimpse as children the young people I came to know, sitting in schools and homes around the country as they made decisions that would determine their lives for the foreseeable future. The variety of answers offered to the question, ‘why medicine?’ both reflect and challenge popular assumptions about why a young person might choose to become a doctor in contemporary India.

As noted in chapter 3, engineering as a profession was imbued with prestige in newly independent India, with grand infrastructural projects central to a vision of national development. Engineering joined medicine and the civil services as a profession that guaranteed both financial security and social status, and this trifecta of prestige has remained fundamentally intact, specifically for India’s middle classes (Fernandes 2006; Wilson 2011).⁸⁰

In her work on career aspirations among the middle class in Kerala, Caroline Wilson argues that, ‘although opportunities for higher education and employment have expanded across diverse fields of the economy, the popularity of medicine and engineering degrees suggests the enduring importance of history, hierarchy and elite ideology in shaping educational practices and career choices’ (2011: 140; also Beteille 1991). For the middle classes, and particularly those pursuing social mobility, medicine and engineering remain the logical – and by far the most respected – options for undergraduate study⁸¹ (Wilson 2011; see also Fernandes 2006, and Liechty 2003 on the consumption of education as a means to crafting a ‘suitably modern’ middle class identity).

For many, and certainly within the secondary education system, as we will see below, medicine and engineering are considered interchangeable career

⁸⁰ The contemporary Indian elite, not unlike its predecessors, tends to send its children abroad for undergraduate study – following an education at the country’s most exclusive schools – from where they may or may not return to India as members of a hypermobile global elite (Fernandes 2006).

⁸¹ The civil services entrance exam is usually taken following an undergraduate degree.

options for the triple form of capital they are each considered to bestow. Since the establishment and growth of India's IT sector, however, the narratives attached to each option have begun to diverge. Based on her research among doctors in Kerala, Wilson (2011) suggests that there is a growing disconnect between the perception and reality of a doctor's lifestyle (which is often defined by low pay, challenging conditions, and, at least in the early years, unrelenting competition over seats for postgraduate training). It is the 'symbolic capital' of the medical profession, reflected through social status and value in the matrimonial market that Wilson argues sustains its appeal (141). Even this 'symbolic', or cultural, capital, tends to suffer, however, in comparison with that now associated with those pursuing careers in IT, finance, or entrepreneurship (following an MBA), all of which are celebrated in contemporary narratives of national development and India's place in the world⁸² (Fuller and Narasimhan 2007; Subramanian 2015).

The national narrative attached to medicine is one of a steady respect for the profession, complicated by a growing suspicion about the motivations of doctors and managers in corporate hospitals, combined with the lure of high private sector salaries for a small minority, and the concern over a national shortage of doctors that I discussed in chapter 1. Discourse about the role of doctors in India's development is usually confined to community medicine departments, periodic policy documents, and a small echo chamber of like-minded advocates, some of whom are retired doctors lamenting the passing of what they consider a less selfish age (Baru 2010). When I raised this question with Dr B, a senior faculty member at AIIMS, he reflected as follows:

...if society's acceptance is of people with more money, then you tend to look for glamour and you move towards that. And if society's acceptance of people serving society is more...so I suppose in the post-independence era, the first 10 years of getting away from the British Raj, people in India here were all wanting to serve the country. While 50-60 years down the line nobody is bothered, whose country, whose British Raj, why am I bothered, who is Mahatma Gandhi? And you see that. There are people

⁸² Of course, as with medicine, these are stratified fields with their own internal hierarchies of prestige.

who have no idea what happened at that time. So a generation that is after me is people who have parents who have not seen those times and therefore don't tell their children about those times and therefore the children don't relate to it. So that's OK.

The differentiation of engineering and medicine suggests that the reasons young people aspire to be doctors might be more varied than generally assumed. Kapil was one of the fourth-year MBBS students who I met at the AIIMS rural health project in Ballabgarh, Haryana. He was one of a minority of students from Northeast India, and, while from a Scheduled Tribe community, had attended a prestigious private boarding school from a young age. Of all the students I spoke with during my fieldwork, Kapil most distinctly embodied a sense of equivalence both between medicine and engineering, and, by extension, between India's most prestigious educational institutions. When I first asked why he had chosen to study medicine, he replied 'I thought I could never do engineering!' It transpired that he had briefly studied engineering at an Indian Institute of Technology (IIT), the engineering equivalent of AIIMS, with its own ferociously competitive entrance exam (see Subramanian 2015):

During my 12th, when I was giving the entrance exam, I was thinking I will go to IIT. So I went there, I thought that I could never do it, I left it and I came here. That's why I am here in medicine. There was no motivation...that I was interested or something like that.

Being 'interested or something like that' is not, then, a requirement for training at India's most prestigious medical college. During his time at AIIMS, given his lack of interest in medicine, Kapil decided to pursue a career in the civil services and by the time we met he had begun studying for yet another notoriously competitive exam. A pass would complete his portfolio of prestige.

Dhananjay was an intern in the final year of his MBBS when we met. From North India, he had also begun an engineering course after school, albeit at a college he described as 'not good'. His mother, who he described as illiterate, advised him to seek guidance from a teacher at his old school:

I went to my teacher to see her, she told me you should go for medicine since you have scored so much, I was the topper in my school. So she told me you should go for the medicine line. I said, OK, let's see. So I went there to Kota [for coaching], and got selected.

Other students had specifically chosen medicine, but often with reference to engineering as the only obvious alternative. Azam was a fourth-year from Kerala. His father wanted him to be an engineer, but he chose medicine, he said, having been inspired by the doctors he encountered during his childhood. Those childhood experiences continue to influence his approach to medicine and he aspires to be a paediatrician.

Dilip, from Rajasthan and also in his fourth year, felt that he had made an unconventional choice by pursuing medicine rather than engineering. Most people choose engineering, he said, 'because they don't want to study for more than 4 or 5 years of college.'⁸³ Dilip's reasons for pursuing medicine suggested a confidence in his ability to go far in his chosen profession, reflecting not only the advantages that facilitated his AIIMS admission but confirming the convertible social and cultural capital bestowed upon students by the Institute:

[In medicine] you get maybe more opportunities to become famous, people know you for your work and then maybe you can go to...much more heights of your career than one would do in engineering.

Priya was an intern and also from Rajasthan. She echoed Dilip's assessment that medicine was a more demanding course of study than engineering and she also noted the appeal of a doctor's status, adding its potential for ensuring a comfortable life. A career in engineering would have been harder work given its itinerant nature, she thought⁸⁴, whereas:

⁸³ See Wilson (2011: 149) for other examples of this reasoning.

⁸⁴ Whereas most people who mentioned engineering to me associated it with the more contemporary context of IT, and software engineering, Priya seemed to refer to the more traditional perception of civil engineering, in which an employee might be posted at various sites around the country for certain periods of time. Subramanian notes this new hierarchy within engineering: 'the difference between conceptual and practical training has become a crucial part of institutional stratification, with the IITs seen as the most conceptual of engineering colleges' (2015: 316).

In the medical field you tend to set-up nicely, make your own, have your private set-up, whatever, and that gives you a lot of respect. I really like that. I like communicating with people so...that's why I chose and later on I realized that, OK, I was satisfied with that.

It took Priya time to feel satisfied with her decision, because her favourite subjects at school had been maths, which inclined her towards engineering. However, she also enjoyed biology, and – crucially – she reasoned that a career as a doctor was ‘better; suitable for a girl’.

The role of gender in career decision-making was also raised by a group of students from CM Medical College in Chhattisgarh, who I spoke to during their visit to AIIMS for Pulse, the annual student festival. One student told me that medicine was ‘the best profession for girls’. Her friends agreed, explaining that medicine allowed for financial and professional independence, which made it particularly appealing to women.

Twenty of the 72 students in the 2011 batch were female, a slightly higher proportion than subsequent batches, in which the number of female students ranges from 15-18.⁸⁵ Anthropologists have written about the calculations that inform parents’ educational strategies for their daughters, discussing the need for domestic labour, and a child’s marriage prospects (Froerer 2011; Jeffrey 2010: 64–66; Page 2005). These accounts tend to focus, necessarily, on the transition from primary to secondary education among lower socioeconomic groups, but there is a rich seam of research potential in gender and decision-making among middle class students in higher education suggested by my time at AIIMS.⁸⁶

Wilson (2011) writes that a significant aspect of the capital attached to medicine in Kerala is its utility in the matrimonial market⁸⁷; I found suggestions of similar calculation by the family of AIIMS students. I first met Neha, a fourth-

⁸⁵ The very small number of female students who agreed to be interviewed frustrated my efforts to explore gender at AIIMS in any depth. Six out of my thirty-six student interviewees were female. Several more agreed to be interviewed, but did not respond when I tried to arrange a meeting. See chapter 1.

⁸⁶ See Donner (2008) for an example of where this journey begins, as middle class mothers in Calcutta seek to place their children in ‘appropriate’ pre-schools. Also Jeffrey (2010: 178) on the need for more research into how women navigate, shape and contend gendered practices.

⁸⁷ While online matrimonial sites have specific sections for doctors, there also exists an exclusive service for doctors at www.doctorshaadi.com [accessed 23/6/16].

year from Punjab, in January 2015. Like Kapil, she was in the process of planning a strategy that would allow her to study for the civil services entrance exam alongside the demands of the MBBS curriculum. I explore the reasons for her decision in chapter 7, but in this brief discussion of gender, I want to foreshadow that Neha's aspirations became so entangled with questions of marriage and kinship that by the time I left Delhi in May 2015, she intended to apply to study postgraduate medicine in the US. As Anjali, another fourth-year student from Rajasthan, struggled to forge a career path based on her own interests, she too was finding the shadow of marriage expectations increasingly difficult to compartmentalize (see chapter 7).

Gendered considerations were not confined to female students. For Santosh, an intern from Rajasthan, the prospect of marriage filled him with foreboding. Like Neha and Kapil, he hoped to join the civil services after completing his MBBS, but he was anxious about the incompatibility of his envisioned career with the family life that would be expected of him. He imagined that his job would entail challenging authorities, and that having a family would be 'a liability'. But any prospect of his family accepting his choice not to marry was out of the question, he said. The stigma of being unmarried was akin to 'being a criminal, or worse'. The career-related explanation gave way to deeper misgivings about marriage and procreation when Santosh insisted in a weary tone that his family would find someone from their own caste and community for him to marry at twenty-five. 'Then I'll have a child and the cycle will repeat for another twenty-five years. What's the use?'

Rahul, a fourth-year from Himachal Pradesh, whose father is a doctor, described his pursuit of medicine as a response to a historical opportunity denied his mother. Rahul explained that his mother had missed the cut-off for acceptance into medical college in her home state by just eleven marks. She was offered a place at a dental college in a different state:

[But] at that time people were very conservative, so nearby there was an agricultural university – it's a very big university in Himachal – and my grandmother said you should go there only, it's nearby home, just a

kilometre or so. So [my mother] said that when I have a son or daughter, he or she should become a doctor, so I decided to become a doctor.

Shankar, an intern from Delhi, described a similar influence:

My mother wanted to be a doctor. She had a dream to become a doctor. But she could not become a doctor. So I decided to become a doctor. But it was not driven by, when I decided, when we had to choose, when we finish our 10th grade, at that time it is mainly driven by what are the outcomes of the career, I mean employment opportunities and all. So that was what it was mainly, but not...I did not have so much self-awareness about me, what I wanted to do at that time.

Of the students who noted the role of family in influencing their decision, Shyam, an intern from Madhya Pradesh, Balraj, a fourth-year from Madhya Pradesh, and Raheem, a second-year surgical senior resident from Andhra Pradesh, were the most explicit about their parents having imposed their preference upon them.⁸⁸ Shyam's father was a radiotherapist; when I asked if this had any influence on his motivation to study medicine, he said 'Yeah, most of it. He pursued me and I got pursued! I liked physics much more than biology, for that matter, so yeah...' Shyam sounded unconvinced by the wisdom of his choice, but he took a pragmatic view: 'It's OK; I mean, there are too many engineers. So I always knew there was not very much scope in the engineering part. I am in a good field, I am in a good place so I'm happy with it.' When we spoke, he had begun studying for the USMLE⁸⁹, with plans to return to India to open a chain of clinics offering affordable care in peri-urban and rural areas.

Neither Balraj, nor Raheem came from medical families, but both attributed responsibility for their decision to their parents.

Actually, initially my parents wanted that. See, nobody was a doctor in my family so I didn't have any idea regarding what doctors are or what

⁸⁸ In Dandekar's study of medical students in Maharashtra, she found that among general category students the top three motivators were 'personal determination', parents, then teachers. Whereas for students in reserved categories the order was teachers, determination, and then parents (2013: 120).

⁸⁹ United States Medical Licensing Examination – a multi-part exam that students must pass in order to pursue postgraduate training in the US.

medicine is, and they wanted me to study this. So that was the reason that I took it. But now I am enjoying. – Balraj

Frankly speaking it was my parents' wishes. I never had any such [ideas about becoming a doctor]. Even later on once I was in this field, I never thought...I just thought that I have to do this, I have to do this, and things went on their way.

– Raheem

Balraj now aspires to be a neurosurgeon and his enthusiasm for the field is palpable when he speaks about it. Raheem also went on to enjoy his medical training; in 2016 he graduated from AIIMS with an M.Ch⁹⁰ in gastrointestinal surgery, one of only thirty-three people do so across India each year.

The most vivid account of a complete lack of autonomy in the process of choosing a medical career came from Dr D, who had studied at AIIMS in the mid-1970s: 'Nobody asked me. In fact I didn't know about AIIMS until I appeared in the examination. So it was my father who filled up all the forms, I just signed those forms without knowing anything, what the options were that were available. My career path was chosen by my father.'⁹¹

Not all parents supported their child's medical ambitions. Both Ashish's and Neha's parents were discouraging for similar reasons, challenging the enduring stereotype of the middle class Indian parent who yearns for their child to become a doctor. These examples are at odds with Wilson's findings that parents in Kerala preferred their children to study medicine rather than engineering, to the dismay of some students who said their parents did not appreciate the years of intense study involved in becoming a doctor (2011: 149).

Neha was drawn to medicine having witnessed over many years her uncle's treatment for a chronic illness. 'So I wanted to do something. My parents were not at all supportive of my decision. They said you will spend your whole life

⁹⁰ Magister Chirurgiae, or Master of Surgery.

⁹¹ In T.N. Madan's survey of AIIMS doctors in the late 1970s, over one third responded that their parents or other family members had been directly involved in the decision to pursue medicine (1980: 55).

studying; you won't have anything else in your life. Then I said no, I want to be a doctor'.

Ashish was a fourth-year from Madhya Pradesh. His parents were both doctors and they subverted any assumption of the automatic reproduction of capital in medical families through their initial objection to their son's choice. They were concerned about Ashish committing to so many years of study before he began earning a living. It is also possible that they had concerns about their son's capacity for sustained academic application. Following his first professional exams, he told me, he had gone off the rails a bit ('I was basically having fun', he said), and had had to retake two mid-semester exams. 'My parents gave me a big scolding,' he said and added that he was almost back on track. Ashish had convinced his parents of his commitment, and explained to me that he was motivated more by medical science as an academic subject than as a route to clinical practice: 'I wanted to know more about the human body. That is why I opted for this'. This affinity for biological science, as opposed to a general aptitude for academic study that makes science a default gateway to a career, receives less attention as a motivator of medical careers than the pursuit of capital. But it was not unusual in my experience – during Pulse several visiting students also told me that it was a fascination with biology and human anatomy that inspired their choice and ensured their ongoing commitment to their studies.

Purush, an intern from Rajasthan, was drawn to medicine by the same fascination: 'the enigma, the human body, and how it works and all.' But this attraction was coupled, he explained, with a desire to alleviate what he saw as 'widespread gloom in society – there is so much pain and suffering'. This social dimension to students' motivation was not uncommon, but it was rarely cited as a primary reason for their choice of medicine. Purush was also unusual among the students I spoke to who voiced such concerns because, unlike others, he intended to continue pursuing medicine as a means to ameliorate the 'pain and suffering' he saw around him.

In her work on medical education in Malawi, Claire Wendland (2010) writes that for many of the students she spoke to, as for many Indian students,

the combination of sociocultural capital and job security made medicine an appealing option. In Wendland's experience, however, most Malawians 'understood medicine as a vocation, a duty, or an opportunity to "uplift our nation"' (80, 74). The desire to become 'agents of development' through medicine was underpinned by a Christian ethos that fuelled a motivation to 'heal Malawi' (81). The motivations of AIIMS students were more diverse. I began my research anticipating (naively, I realized) that a discourse of development would arise more often than it did. The most notable contrast with Wendland's work was that the majority of AIIMS students who mentioned 'development' or the politics of healthcare as a concern intended to leave clinical medicine following their MBBS. I explore this in chapter 7.

For many of Wendland's student informants in Malawi, 'medicine felt less like a choice than an inevitability' (ibid.: 73), given their status as highly educated members of a tiny urban elite and the dearth of alternatives in the small, impoverished nation. At AIIMS, it was growing up in a medical family that made the career feel inevitable for some students. Of the 27 MBBS students I interviewed, ten grew up with doctors in their immediate family, and 17 were the first in their family to study medicine. Vivek, an intern from Haryana, articulated a mixture of motivations: the intellectual challenge of complex diagnosis and medical innovation, combined with a varied work life and the capacity to help people in need, but he acknowledged that this conclusion was largely informed by having witnessed such opportunities as he grew up surrounded by doctors (although his parents, like others above, were not enthusiastic about his choice, given the amount of work involved).

The response of Mihir, an intern from Haryana, by contrast, suggested that he felt his horizons had been limited by both of his parents (and several other family members) being doctors, to the extent that he overrode his preference for maths (as did Shyam and Priya) in order to pursue medicine:

My favourite subject was always maths. I didn't want to go into biology, but I couldn't visualize myself as anything other than a doctor. I had to

get into biology by force. I suppose it's because my parents are doctors and it's the only profession I was much exposed to during my growing years.

Anjali was the latest of five generations of doctors, a lineage that had a clear impact on her perceptions of medicine and healthcare as she grew up:

Every single person I know is a doctor! I mean I didn't know you had to take an appointment from a doctor, because all I needed to was just call up and say, 'Hey Aunt, this is the problem.' Seriously! Probably until 6th standard, I genuinely thought that if you study, if you work hard, you are going to be a doctor. Like there is no other option out there. That's genuinely what I thought.

Despite this inculcation of medical habitus at home (Bourdieu 2010; Wilson 2011), as she progressed through school, Anjali became aware of other possible options that depended on her choice of subjects. This excerpt confirms how future-determining educational choices at school are structured and valued, as well as noting the sense of security that ultimately determined Anjali's decision to pursue medicine:

Yes, so, in 10th standard you are supposed to choose between biology and mathematics, and arts is...I was like 16 at that point and the conception was that humanities was for those who cannot make it to the sciences and you never really choose to go into humanities. And commerce was full of those who had a businessman kind of family. So science was the natural option and between biology and maths there was a choice, so I just took both of them, and I studied both of them, unlike anyone else in my school. And then when the time came to decide, I had the option of going into engineering, which is another hot thing to do in India, and becoming a doctor. I wasn't sure of myself, I didn't know what I liked more. I was like, OK, this is a safe choice, might as well do it.

For Nikhil, an intern from rural Uttar Pradesh, having grown up around medicine was a less equivocal inspiration. His father was not a trained physician, but his educated status in their home village meant that people approached him for medical advice, and he was later selected for some first-aid training through

a government programme.⁹² His premature death was also a factor in Nikhil's decision to study medicine:

Actually from the beginning when I saw my father doing something to treat, giving some pain-relief...someone came to you with pain and my father gave something, the person would say thank you, doctor, and that would give me pleasure. I feel better that I can treat, if someone calls me doctor, it's very passionate. And I want to help people this way. And the other thing is my father was suffering from brain tumour and he expired when I was in class 7. So at that time I turned more towards medical science...I felt I had to do something more in this field, so that I can make other children happy, some sentiments are related to this.

Growing up 'in a medical family' had a different connotation for Nikhil than it did for Mihir or Anjali, and yet for all that Nikhil's father would not be considered 'a proper doctor' by students at AIIMS – indeed would likely be dismissed as a 'quack' by most – it was Nikhil whose early observation of the social life of medicine encouraged him to become a doctor, rather than being a default option that he felt compelled to choose.

Now that we have an idea of the various motivations of our medical students, the following sections explore the process of gaining access to AIIMS, taking into account historical currents that continue to inform pedagogical strategies, before looking at the entrance exam itself and the implications of rank for both the successful and those who do not make it.

'Noncombustible data'⁹³: a brief history of mugging up

We in India are apt to pay more attention and more time to book-learning than to the practical side. In our country there is far too much of a habit of memorising things in order to pass examinations. It is a very dangerous

⁹² See Pinto (2004) for analysis of these dynamics in rural UP.

⁹³ 'Peace, Montag. Give the people contests they win by remembering the words to more popular songs or the names of state capitals or how much corn Iowa grew last year. Cram them full of noncombustible data, chock them so damned full of 'facts' they feel stuffed, but absolutely 'brilliant' with information. Then they'll feel they're thinking, they'll get a *sense* of motion without moving. And they'll be happy, because facts of that sort don't change.' - *Fahrenheit 451* (Bradbury 1998: 61)

habit. Apart from a person not learning anything, he becomes stultified and possibly is not capable of growth later on. I think it is essential that the practical side is stressed much more in all our scientific pursuits and education.

– Jawaharlal Nehru, speech to the Medical Education Conference, New Delhi, 1955 (in Singh 1988: 132).

Sabra, a Maldivian student in her intern year, laughed when she recalled the pedagogical culture shock she experienced during her first year at AIIMS as she struggled to learn all the examination material in the limited time available. ‘For us it was a lot of cramming, so we were like, how are the Indians doing this?! They are so smart! It was very difficult for all the foreign nationals. We kept on failing.’ She remembered a conversation with a friend studying medicine at Imperial College in London. The difference, she said, was that the books her friend used for reference, to supplement lecture notes and seminar learning, were those that AIIMS students tried to commit to memory in their entirety. The disadvantage was not being able to retain the large volumes of information she read. But on the upside, she said, the catch-all approach to ‘mugging up’ meant that ‘without knowing, we kind of learn a lot of things, I guess.’

As in so many things, education in contemporary India is notable for its diversity of form;⁹⁴ schools vary in terms of provenance, religion, language, exam boards, and of course – particularly in the wake of the economic policies of the early 1990s – whether they are government run, NGO, or private initiatives (see Chopra and Jeffery 2005 for case studies reflecting these differences; Sarangapani 2014). For many students, however, rote memorization and the accumulation of ‘facts’ through ‘mugging up’ continues to dominate pedagogical experience, despite periodic efforts at educational reform (Jeffery 2005; Kumar 2005; Panikkar et al. 2011; Priyam 2015; Sarangapani 2014; also Page 2005 on contested notions of quality in education). Students navigate regular cycles of highly competitive examinations, to be assigned a numerical rank in a matrix of

⁹⁴ This phenomenon pre-dates the colonial presence in India, albeit with a predominant emphasis on the education of upper-caste males (Bayly 1996: 281; Crook 1996: 10, 20; Mendelsohn & Vicziany 1998: 86).

achievement, with determinist consequences that often cement pre-existing social advantages (Bourdieu 1986; Bourdieu and Passaron 2015; Jeffery 2005). What may appear to be largely a question of the mechanics of learning, however, contains its own histories – of the definitions of, and control over, knowledge, and the techniques and purposes of its transmission. The currents that ripple through contemporary Indian education reflect the influences of three intersecting eras: the pre-colonial, the post-colonial, and arguably most viscerally, the colonial era itself (Bayly 1996; Crook 1996; Kumar 2005; Sarangapani 2014).

The systematization of colonial influence over Indian education began with the 1835 English Education Act, forever associated with Thomas Babington Macaulay's Minute on Indian Education that denigrated indigenous knowledge and advocated for English as the main medium of instruction in place of Persian, and for the civilising influence of a curriculum based on Western science and literature. Informed by Victorian Britain's twin preoccupations with morality and scientific rationality, a system of education was deployed in India that aimed to reproduce British behavioural values, establishing and maintaining a loyal elite, and imparting 'knowledge' to those hitherto denied it – while simultaneously providing a moral justification for empire (Crook 1996: 21; Kumar 2005: 35).

A perceived division between practical and theoretical knowledge⁹⁵, suggesting that knowledge in pre-colonial North India tended to be 'specialized and involuted, rather than interactive and generalized' (ibid.: 286), was a particular preoccupation of William Arnold in Punjab of the late 1850s.⁹⁶ Arnold was appointed Director of Public Instruction in Punjab in 1856, and the reports he wrote of his tour of the province in 1857-58 reflect an earnest commitment to

⁹⁵ Crook suggests a conceptual division of 'knowledge' into raw data and the competence to act on it as a means of understanding histories of education and knowledge transmission (1996: 4, 11).

⁹⁶ Bayly questions too rigid a hypothesis about hierarchical and segmented knowledge and 'knowing persons', and suggests that by the time the British imposed their own administrative systems, there was already a degree of knowledge sharing and outward orientation among epistemological communities, suggesting that the 'revolution' in education associated with colonial power had its seeds in the pre-colonial Indian landscape of knowledge transmission and transfer (1996: 290-91, 309).

educational methods and ideals, and a general perplexity in the face of existing Indian practices, including the emphasis on memorization (Kumar 2005: 52–56).

The printing press didn't reach Punjab until the early 19th century – during Arnold's time, the ownership of printed texts was still rare. Reading aloud was therefore both a means of memorizing and of sharing texts, with greater emphasis placed on rhythm and intonation than on interpretation of meaning. This reflected the epistemological stance that held that the meaning of such texts as the Persian *Pandnama* or *Khaliqbari* resided in the texts themselves, rather than in the mind of the reader (ibid.: 55–56). As Crook (1996) notes, the oral transmission of knowledge is also an effective means of managing the limits of its dissemination. He suggests that the resistance to the printing press from the Hindu and Muslim religious elite was primarily overcome as a response to the epistemological threat posed by the new colonial power (16).⁹⁷

In nineteenth-century Punjab, a new curriculum was introduced, which reflected the colonizers' Victorian romance with geography and natural history. As noted, the colonial motivations fuelling the expansion and systematisation of education were various and entangled: the creation of a loyal elite, and the dissemination of what were considered the enlightenment's rational, scientific fruits; education for girls, and teaching in vernacular languages; all intertwined with 'moral uplift' through Christian ethics. What is clear amidst this entanglement, however, is that with the imposition of the new education system, the British colonial power made an unequivocal statement about the definition of, and control over, valid forms of knowledge. As Crook writes, 'by creating a core and compulsory curriculum the colonial power ensured less scope for critique; alternative curricula had to be squeezed into overtime' (1996: 19). This is not to say that the colonial system extinguished all other forms of learning. With the opening of the civil services to Indians in 1833, however, the colonial curriculum became the established pathway to the salaried benefits of government employment.

⁹⁷ Also see Robinson (1996) for a historical discussion of memory and the impact of print on Islam in South Asia.

For administrators such as Arnold, committed to an educational ideal that promoted critical competence applied to a knowledge of 'fact', the effect of the new curriculum might have been disappointing. In his reports, Arnold had recognised that 'consigning to memory large texts and bits of information was the prime skill used in traditional, indigenous pedagogy', yet his enthusiasm for the 'transformation' that had taken place in education in Punjab, that saw boys able to narrate 'the early Muhammadan invasions of India,' adhere to 'the first four rules of arithmetic,' and 'pass a good exam' in geography, seemed to overlook – whether wilfully or otherwise – the explanation that these results were largely obtained using the same techniques of rote learning and memorization he had so disapproved of (Kumar 2005: 60).

'Textbook culture', as Kumar has called it, grew out of and was institutionalized by 'codified procedures for the recruitment of teachers' and the consequent devaluation of the profession, the colonial administration's 'elaborate machinery for inspection,' plus rapidly entrenched 'norms of evaluation for the award of scholarships and certificates' (2005: 66). Teachers were subordinated to a low rung of an institutional ladder, reducing them to low-paid government servants responsible for shepherding students through exams.⁹⁸ Despite the ostensible concerns of policy architects with comprehension and analysis, textbooks quickly became the de facto curriculum, cemented by the identification of specific portions that would be used in examinations: 'what meaning the lessons in the textbooks could have had for the student was inextricably linked to the urgency to pass in the examination' (Kumar 2005: 68).

With notoriously high failure rates, fear of examinations (among those in a position to take them) 'became part of the lore of childhood and adolescence' (ibid.: 69). The much-loved author Premchand captured the strategic and faintly absurd nature of studying for exams in his 1910 short story *Bade Bhai Sahab*:

⁹⁸ The problematic contemporary consequences of the devaluation of the teacher's role include absenteeism and the arbitrary (mis)treatment of students (Chopra 2005; Priyam 2015: 210-217).

...And you'll have to study English history. Remembering the names of kings isn't easy. There were eight Henrys – do you think it's easy to remember what happened during each one's reign? And if you write Henry VIII instead of Henry VII you lose all your marks. Gone. You won't even get a zero ... but why care about these exams?! Just write whatever is written in the book. All they want is that we keep putting words on paper. And they call this process education. But in the end, what's the use in studying these absurd things? (Premchand 1910).⁹⁹

Arguably, the demands of the colonial administration for order and control took precedence over concerns about the substantive content of education, and its capacity to encourage critique and contemplation.¹⁰⁰ At the university level in particular, Kumar argues that exams became a method of establishing and maintaining an acceptable norm (2005: 68). A centralized educational bureaucracy set 'uniform standards' for scholarships, employment and promotion, and in doing so projected an argument for colonial rule based on 'principles and impartial procedures' (ibid.). Reintroducing Bourdieu's ideas about how academic credentials produce cultural capital might enrich this analysis:

With the academic qualification, a certificate of cultural competence which confers on its holder a conventional, constant, legally guaranteed value with respect to culture, social alchemy produces a form of cultural capital which has a relative autonomy vis-a-vis its bearer and even vis-a-vis the cultural capital he effectively possesses at a given moment in time. (1986: 88)

As a form of cultural capital in colonial India, a particular type of education became – and remains – a powerful means of distinguishing oneself; a differentiation made tangible and objective through mark-sheets, certificates and medals that proclaimed achievement from their proud positions on walls or in cabinets (Kumar 2005: 39). While these material expressions of achievement (Bayly 2013: 158) continue to be important signifiers of cultural capital in the present, their capacity for conversion, particularly for school leavers, cannot be

⁹⁹ My translation.

¹⁰⁰ Bayly notes, however, that elite institutions such as Delhi College, the Hindu College, and Jay Narayan Ghosal's college in Banaras did produce 'a new type of educated man' who engaged in religious and literary debate, and with critical history (1996: 306–307).

taken for granted; uncertainty about this capacity informs decisions in some families about whether or not to continue a child's education (Froerer 2011: 704; Bourdieu 1986: 95).

The ambiguities of education (or, the opportunity to aspire)

Aspiration is a key trope in NGO campaigns for improving access to education; the child who declares her intention to become a teacher or a doctor in order to improve the lives of those around her is an emotive proof of education as the engine of social mobility and development (Oxfam India 2015). The support of socially-minded donors, campaigns suggest, continues to ensure that aspiration plus determination will equal success for newly educated children. Among contemporary academic voices, those of Jean Dreze and Amartya Sen (2014) are perhaps the most audible in their promotion of education as an unequivocal good. Although Mendelsohn and Vicziany argue that from the 1940s onwards, 'it became an article of nationalist faith that education of the Indian poor, including Untouchables, was a necessity for the development of the nation' (1998: 125), the Right to Education Act (RTE) was not passed until 2009. Subsequently, India has seen improved enrolment rates, particularly in primary education.¹⁰¹ As is regularly noted, however, enrolment does not equate with attendance or completion, and the monitoring of this crucial dimension is still unreliable (Oxfam India 2015). Nor does it speak for quality.

Scholars of India have challenged the idea that education possesses an inherently positive value. Patricia Jeffery argues that 'education *as it is practised* is profoundly ambiguous in its effects,' hence her use of 'educational regimes' 'to locate values in a broad political terrain that encompasses the global, national and local contexts' (2005: 13, original emphasis). Levinson and Holland describe education as a 'contradictory resource' (1996: 1), 'conferring advantages and

¹⁰¹ In its figures for 2014, the Ministry of Human Resource Development reports a gross enrolment ratio of 99.3% in primary education (class 1-5), 87.4% in upper primary (class 6-8), declining to 73.6% in secondary (class 9-10), and 49.1% in senior secondary (class 11-12). Higher education had an enrolment ratio of 21.1% in 2014.
http://mhrd.gov.in/sites/upload_files/mhrd/files/statistics/EAG2014.pdf [accessed 25/6/16].

bringing about social mobility for some while reinforcing positions of inequality for others' (Froerer 2011: 696). While the great expansion of India's middle class is a visible demonstration of social mobility stemming at least in part from increased access to education, Jeffrey, Jeffery and Jeffery (2005) suggest that there has been an analytical over-emphasis on the creation of human capital through access to education, and insufficient attention to 'issues of power, social change, and the meanings attached to education' (2085; also see Jeffery et al. 2005). They address this lacuna in their study of the educational aspirations and outcomes among young men of different castes in Bijnor, a rural district in Uttar Pradesh.

Deploying Bourdieu, Jeffrey et al. (2005) argue that the dominant Jats in Bijnor are consolidating their position as the local elite through a change from direct inheritance to a form of 'mediated reproduction' that uses existing forms of capital – wealth, status, and social connections – to secure privileged access to superior schooling and government employment (*ibid.*).¹⁰² Conversely, the lack of economic, cultural, and social capital among the lower caste Chamars acts as a formidable barrier to the quality of education they can access, and, by extension, to salaried employment. Sons of Chamar families are regularly withdrawn from school in times of financial crisis, usually provoked by the need to save money for a daughter's dowry, or to pay medical bills in times of ill health (*ibid.*: 2094)¹⁰³.

Some Chamar families were beginning to 're-evaluate their educational strategies in the face of poor occupational outcomes for educated Chamar young men (Jeffrey et al. 2005: 2096; also see Ciotti 2006). This speaks in particular to the machinations through which the cultural capital of academic achievement may – or may not – be converted into economic opportunity, and how this may change over time:

¹⁰² This also recalls the work of Manuel Castells (2009) on 'the information age', in which intellectual property has become increasingly important as a determinant of social class.

¹⁰³ There is a suggestion here of how the neglect of public healthcare by the state comes to reinforce itself to its own detriment. Perhaps it is not too great a stretch to claim that India's shortage of doctors – particularly in rural areas – is in part compounded by a punitive system of unregulated private healthcare that disrupts formative years of schooling, even if those affected face significant additional barriers to achievement, as the literature under review suggests.

Because the material and symbolic profits which the academic qualification guarantees also depend on its scarcity, the investments made (in time and effort) may turn out to be less profitable than was anticipated when they were made (there having been a *de facto* change in the conversion rate between academic capital and economic capital). (Bourdieu 1986: 88)

We see another example of this ambiguity in Peggy Froerer's (2011) work on education and social mobility among *adivasis* in rural Chhattisgarh. Whereas Jeffrey et al. (2005) illuminated the means by which education reinforced entrenched inequalities in Uttar Pradesh, Froerer is concerned with the production of *new* inequalities emerging as a result of differential experiences of education among Oraon Christians and Hindus in the village of Mohanpur. The Catholic Church has helped Oraons with education, and enabled some to secure salaried employment beyond the village, to an extent that far outstrips opportunities available to Hindus in Mohanpur. Consequently, Froerer writes that many Hindu parents 'ultimately consider education to be an expensive and time-consuming means to an end that is not achievable by people such as themselves, who lack the connections and economic resources to translate school certificates into a meaningful form of employment' (2011: 704).

Amanda Gilbertson's (2014, 2016) analysis of schooling in middle class Hyderabad suggests that perceptions of value in education systems both enable and alter with class mobility. Gilbertson found that 'international' schools are valued by 'recently rural upper-middle class' parents for their emphasis on 'exposure', which they anticipate will give their children an advantage in a globalized marketplace over those whose education is based on rote learning. Gilbertson argues that such schools offer parents an opportunity to convert recently accumulated economic capital into the cultural capital 'needed to legitimise their position in urban middle-class life' (2014: 218). A concern about the limitations of rote learning was also voiced by wealthier Jat parents in Uttar Pradesh, who sent their children to urban centres for secondary schooling that would install the critical, contemplative attitude deemed important to the

employment opportunities of graduating students (Jeffrey et al. 2005: 2092; also Benei 2008).

In colonial India, Kumar states that ‘facilities for English education were quickly exploited by the better-off families of Brahman and other higher castes to equip their children with the new skills, knowledge and certificates required for employment in colonial administration’ (2005: 37; Mendelsohn & Vicziany 1998: 80–81). In the contemporary context, the advantage conferred by English-medium education is more significant than ever, both in the public imagination and in reality, even as standards vary, other forms of capital influence access to opportunities, and quandaries arise about the denigration of regional languages as the mode of instruction (Benei 2008: 90–91; Fernandes 2006; Jeffrey 2010; Parry 2005; Sheth 1995).

Of the AIIMS students I spoke to, everyone had been to English-medium schools, and all were privately educated, other than Purush and Nikhil, both Scheduled Caste (SC) students who had attended selective government schools for academically gifted children. Two students I met came from two of India’s famously elite boarding schools, but they formed a minority in my experience. ‘Convent’ education – at one of the many Catholic or Jesuit schools established by missionaries across colonial India – was more common.

Dhananjay, who we met above, had a place in the Scheduled Tribe (ST) category at AIIMS (see chapter 5) and was convinced that without his English-medium primary education he would not have been there. He explained that he wouldn’t have had such an education if his father had not had the opportunity to leave his home village after completing class 8, subsequently securing a government position with Indian Railways. His father then pursued his secondary education through a correspondence course.

I came to city, and I got my early education in an English-medium school, that’s why it became possible. A guy from a reserved caste also, but has

studied in a Hindi-medium school, can't get up to here. It's not possible.¹⁰⁴

Aspiration, then, is born pre-entangled with structures of caste, class, and gender¹⁰⁵ that can also be understood through the lens of capital(s). Official statistics that reflect increasing enrolment and attendance celebrate achievement while obscuring heterogeneous experience. More children are attending school in India than ever before, but their experiences of education, and the opportunities that await them are diverse and deserving of attention. The opportunity to translate aspiration into achievement is not available to everyone, and of those who make the attempt, not all are rewarded for their efforts. As Peggy Froerer puts it: 'by disregarding the differentiated ways in which schooling is experienced and valued by people within a similar demographic, the "intrinsic benefits" that are supposedly associated with education will remain restricted to a privileged few' (2011: 710).

I have explored these examples of the ambiguous nature of education in part as groundwork for troubling the discourse of reservations and meritocracy that we will encounter in the next chapter. But also in an effort to suggest that while winning a place at AIIMS is exceedingly difficult, getting a toehold on the aspirational ladder that leads to taking the entrance exam constitutes a challenge of a much greater order. In this sense, it seems valid to claim similarities between the new AIIMS undergraduates, and the Malawian medical students of whom Clare Wendland writes that, by the time they 'stepped between the painted metal gates and entered the medical school, and to an extent far greater than their North American or European counterparts, they were already exceptional' (2010: 73).

¹⁰⁴ As we will see in chapter 4, it is not impossible for students to reach AIIMS following Hindi-medium schooling, but the institution poses significant challenges for students with limited English.

¹⁰⁵ See Chopra (2005) on parental decision-making about the different educational trajectories of daughters and sons. And Krishna (2014) on how disadvantages combine to preclude social mobility through education.

‘Lakhs of people just mugging stuff’¹⁰⁶

While a dependence on rote learning and memorization is called into question by aspirational parents as well as scholars of education, connoting government schooling and an outdated pedagogy that ill-prepares upwardly mobile children for cosmopolitan life, it remains the case that without considerable training in these skills, a candidate is unlikely to win a place at AIIMS. Officially, any student who has completed class 12 exams in English, physics, chemistry, and biology with a pass of 60% – or 50% for SC/ST candidates – is eligible to sit the AIIMS entrance exam. But as Purush explained, ‘in school I did well and all, but that’s not enough for this pre-medical thing.’

My intention in the following discussion is not to suggest that the AIIMS entrance exam is solely a test of memory (even if particular informants hold this to be the case), or that a historical tradition of rote learning transposes directly onto contemporary competitive examinations. Memorization still dominates studying techniques, but the exam also demands that this content be appropriately managed and deployed in order to answer questions correctly. The function of rote learning here is therefore more complex than that required for a school exam, or in Fuller’s (1997) example of priests memorizing Vedic texts for the purposes of ritual recitation in 1980s Madurai.¹⁰⁷ In the AIIMS admissions process, we hear echoes of the past, rather than observing a direct equivalence.

Of the 27 MBBS students I conducted in-depth interviews with, all had attended coaching classes to prepare them for the AIIMS entrance exam and the All India Pre-Medical Test (AIPMT).¹⁰⁸ Of those, most had attended classes during their

¹⁰⁶ Literally, one lakh is one hundred thousand.

¹⁰⁷ Having observed the rote learning undertaken by Brahmin priests working at the Meenakshi temple in Madurai, Fuller notes that ‘above all else, verbatim memorisation of Sanskrit texts is the principal objective of the Agamic religious schools’ teaching system and all the gurus insist that memorisation is far more important than understanding.’ (1997: 14). That verbatim memorization can be achieved without full linguistic competency is not particularly surprising, and has its parallels in other systems - Fuller cites the ability of non-Arabic speaking Muslims to memorise the Quran, and the erstwhile commonplace scene of English children chanting Latin conjugations (ibid.: 14–15).

¹⁰⁸ The AIPMT (which over 500,000 candidates sat in 2014) allocates ranks, according to which students choose an eligible medical college. The AIPMT results are announced before those of

final two years of school, beginning as they entered class 11. Deepak, in his intern year, recalled the coaching regime: ‘...from two to eight, classes. Everyday almost. Except two days, weekends, or Monday and Friday, or something. And it was a long process with tests every few weeks. And in the end, after finishing higher secondary school we have a test series, we prepare for it.’ The National Council of Educational Research and Training (NCERT) science textbooks became Deepak’s constant companions: ‘We used to sleep with it, be with that book every time we can ... I would say I have read that book six or seven times. Whenever we get time, just read that book, that’s it.’ He shook his head as he recalled the subordination of an adolescent social life to exam preparation: ‘as far as I can say, I watched only three or four movies in two years, that’s it. It was like that.’

Balraj took coaching classes during class 12, noting that he attended for ‘just one year’. The process was intense: ‘Actually we had to study a lot, 14-15 hours a day, at a stretch. And during the three-four months just before the exam, it was more intense, like 17-18 hours per day.’ For Nikhil, preparation involved leaving his hometown in Uttar Pradesh and moving to Delhi to attend a particular coaching institute for five hours a day, four days a week. His elder brother encouraged the move, advising him that, ‘if you join coaching, then you will get a competitive environment, you can compare yourself, where you stand.’ Life in Delhi revolved around the competitive ethos of the institute: ‘coaching was the only thing, nothing else. And I was here alone as a paying guest, so no friends, only coaching.’

Nikhil’s experience of leaving home to attend a coaching institute is not unique. Purush was selected for secondary schooling at the Jawahar Navodaya Vidyalaya in Rajasthan – a network of government schools established to provide free secondary education to gifted students from rural areas – where he lived from class 6 to class 12. Having developed an interest in biology and anatomy, he moved to Kota, also in Rajasthan, to attend a coaching institute for a year.

the AIIMS exam – most students therefore begin preparing for admission elsewhere and switch to AIIMS when they get notice of their success.

Dhananjay also spent a year in Kota for coaching, an experience he described as ‘lakhs of people just mugging stuff.’

Historically known more for being a railway hub, in recent years Kota has gained a reputation as India’s premier coaching city, preparing students for engineering and medical entrance exams, and spawning an industry in the process worth, with its associated hostels, copy shops, etc., an estimated Rs. 2000 crore (£200 million) a year (Rawal & Quazi 2015). A cursory Google search gives a directory of nearly 200 coaching institutes – from small home-based set-ups, to franchises with institutes across the country. Online fora such as Quora are filled with prospective students seeking advice about which institute to attend, with variables including financial resources, specialist subjects, and those best for ‘droppers’ or ‘repeaters’ – those who have already failed entrance exams for medicine or engineering colleges. Krish, a seventh semester student from Kerala, only decided to pursue medicine when he reached class 11. His preparation suffered, he told me, from a poor maths teacher, which prompted him to take a year out to study for the entrance exams after completing class 12. ‘I am a dropper’ he said.

A year’s tuition in Kota costs between Rs. 50,000 and 1 lakh (£400-£1,000), with accommodation and additional expenses totalling at least Rs. 80,000 (£800) (Malhotra 2013). In an almost dystopian twist to a tale of relentless examinations, given the high demand and the development of a hierarchy among institutes,¹⁰⁹ some of the most popular coaching establishments hold their own admissions tests for which separate coaching centres have been established. Tie-ups between schools and coaching institutes mean that some students attend full-time classes at the institutes, only returning to school to take class 12 exams. Available from class 6 onwards, this facilitates a scenario in which the substance of education from eleven-years-old is geared towards passing college entrance exams. The student ranked third in the 2016 AIIMS entrance exam had been taking coaching classes since class 9 (Quazi 2016). Family investment in such strategies produces what Susan Bayly describes in a

¹⁰⁹ In 2016, one particular coaching institute produced several top ten AIIMS candidates, and the top three in the JEE (Quazi 2016).

Vietnamese context as ‘achiever collectivities’ (2013: 161), whereby the ostensible achievement of a single individual disguises the involvement of multiple actors. In chapter 7, I suggest that an awareness of this collective investment might have consequences for the career choices of some AIIMSonians.

Kota’s coaching environment is described in *Revolution Twenty20*, a book by India’s highest-selling English language novelist Chetan Bhagat (2011), who writes for and about India’s young and aspirational urban middle classes. Gopal, the story’s protagonist, fails his first attempt at the JEE – the IIT entrance exam – and goes to Kota at his father’s behest for a year of coaching to prepare him for a second attempt. There he encounters an entire ecosystem, with its own rules and hierarchies, that exists in response to an annual cycle of competitive examinations. Many students in Kota live with a variety of pressures, and for some the demands of studying, financial concerns, homesickness, and the personal anxieties of adolescence become unmanageable. And not all students want to be there in the first place (Ghosh 2016). In October 2015, the Hindustan Times reported that 72 students had committed suicide in the five years to date (Rawal & Quazi 2015). Five of these suicides occurred in June 2015 alone (Dutta 2015).¹¹⁰

Reflecting on his own experience, Dhananjay said:

So these are coachings only for...who can afford from middle class. A guy from a poor family can't afford all these things. He first goes to Hindi-medium school, then he has to pay 50,000 for coaching, it's not possible for them to come here and...so always like people who are above middle class, only they can make it up to here.¹¹¹

The perceived necessity of coaching thus appears as another barrier to progress along the path to AIIMS, an augmentation of the cultural capital demanded by a

¹¹⁰ While I am not able to delve further into this theme here, a glimpse of the coaching industry in Kota suggests an ecosystem ripe for anthropological study, not least in an effort to interrogate the entanglement of education and health, made so visible by the absurdly tragic situation in which a young person commits suicide under the pressures of competing for the opportunity to study medicine.

¹¹¹ Dandekar describes the pressure of loans that poorer students at the college she studied in Maharashtra had taken out in order to afford coaching (2013: 127).

process that impedes or excludes aspirants already disadvantaged by substandard education, minimal exposure to English, and relative poverty (Bourdieu & Passaron 2015: 153–154).

Taking the test...

Following years of preparation – both tacit and overt – the time arrives for many thousands of hopefuls to sit the AIIMS entrance exam. The computer-based test takes place during three-and-a-half hours in morning and afternoon shifts at over 150 centres around the country. The paper comprises 200 questions and is divided into four sections: physics, chemistry, biology, and general knowledge, and can be taken in either English or Hindi.¹¹² Of the 200 questions, 140 are multiple choice, and 60 are ‘reason assertion’ based, whereby the candidate has to ascertain the correspondence, or lack of, between a stated assertion and the reason provided for it. This aspect differentiates the AIIMS exam from other medical entrance examinations and gives it a reputation for being more challenging. In 2014, a group of AIIMS students established an online exam preparation and mentoring service for prospective candidates. A member of their team told me that they focus particularly on training students to answer the reason assertion questions. The organization’s profile was raised in 2016 after one of their students topped the entrance exam.

Rahul took the exam at a government school that acted as the testing centre in Chandigarh. ‘I looked at the question paper and I thought it was so-so – you know a few, you don’t know a few.’ He recalled attempting around 180 questions, of which only four were from the general knowledge section. ‘Because I didn’t know anything!’ he said. ‘They were asking pretty tough questions. Like this singer belongs to which *gharana* [house of classical music] and things like that. I didn’t know anything about that!’ Rahul later learned that he had secured the 33rd of 37 general category seats, but at the time he had no idea how he had

¹¹² Note that Dhananjay’s assertion above that English-medium education is necessary to reach AIIMS is in spite of the Hindi option in the exam. I was told that only a small minority of applicants choose this option.

fared, only having taken the exam to please his father (also a doctor). He had achieved a national rank of 128 (of around 400,000) in the AIPMT, and he was happy with the prospect of attending medical college at home in Shimla.

So that was the plan. And next day was AIIMS. I was like, why give AIIMS, I'm not going to get selected in it, I'm not such a brilliant child – 128 – and the top 30-40 will get selected in AIIMS, that's it. So [my father] said that you just give one paper for me, this I'm requesting you, just give it for me. I had also applied for JIPMER¹¹³ and all, so I said I'm not going to give JIPMER, and he said but you should give AIIMS.

Rahul was relaxed when he took the exam. He remembered that it was a beautiful morning after heavy rainfall in Chandigarh; he and his father went for a walk as they waited for the test centre to open. Several students suggested that the main reason they got admission was that they were relaxed during the test, having already secured a place at a college they were happy with. In a similar story, Priya told me that she was happy with her place at Lady Hardinge Medical College in Delhi, and only took the AIIMS exam to satisfy her mother.

I just gave it with a very cool mind because I knew I am already selected. Maybe that worked...there was no pressure at all. I got into the bus at night, overnight I did my journey, morning I gave my exam and came back. And I was not even waiting for the result, and the result came and I was like, oh my god! It was the best gift...

Rahul and his father were about to collect the admission letter from the college in Shimla when a call came to confirm his AIIMS admission. 'So my father was so happy! And I was like, a face-palm thing, like that! I was banging my head, what the hell did I do?! Because I didn't want to go.' But Rahul had made a twofold deal when his parents had agreed not to send him away from home for coaching. Firstly, that if he didn't get selected for a good college on his first attempt he would drop a year after class 12 and leave home in order to prepare for a second attempt at a coaching centre. And secondly, that he was free to reject offers of

¹¹³ Jawaharlal Institute of Postgraduate Medical Education and Research in Pondicherry (which includes an MBBS course, despite its name), another highly regarded college.

admission from any college in favour of Shimla – except AIIMS. ‘So I realised: now I have to leave.’

Rahul’s reaction to his admission was more ambivalent than most. Narratives combining surprise and delight were more common, reflecting the special place occupied by AIIMS in the imaginations of these high-achieving students, all of whom had already secured places at respectable alternative colleges given their ranks in the AIPMT.

It’s miraculous I cleared it. I never expected to clear that exam. And my parents just said that give it for sake of giving it. Because my rank in AIPMT was 58. Here there are 37 seats, so it was kind of dicey. – Ashish

Despite being ranked first in the AIPMT, Neha – the first medical student in her family – was still stunned by her acceptance to AIIMS: ‘I was not at all expecting it! I just cried when I got to know the result!’ For Nikhil, the joy he felt on news of his admission was still tangible when he spoke to me about it four years later: ‘It was amazing! I was thinking like, it’s AIIMS! My dream come true!’

Dhananjay had already begun the semester at a medical college in Ahmedabad when he learned that he had been offered a place at AIIMS, having been on the waiting list.

I was like praying the whole one week, that I should get cleared. I was praying a lot. When I got cleared I was very happy. My family was very happy...When that letter came to my home, that my waiting is cleared, it was in English. Then they called someone, my dad called his friend, they had to read out the letter. That guy told my relatives that my waiting is cleared and call him back to Delhi.

Krish, a fourth-year from Kerala, was reflective when I asked if the thrill of admission – the sense of being special – had endured through his time at AIIMS: ‘Yeah; I mean, not always, but sometimes I get the feeling that why have I got selected, why in the 72 I got selected and not among the one lakh students who didn’t.’

This moment of admission, and the reactions it produces, recalls how Long and Moore (2013) understand such achievements as events, the experience

of which 'is both material and semiotic; concretely embodied and affectively charged, yet also known and elaborated through the work of fantasy and the imagination' (11). The accomplishment of such a feat, and the recognition of possessing the necessary capacity, Long and Moore elaborate, generates a 'new knowledge' about the achiever, both in relation to herself and potentially to others 'who either have or have not enjoyed the same achievement, either in the present instance or in the past' (13).

The impact of this achievement on a student's subjectivity has consequences, I suggest in chapter 7, not only for their immediate decisions upon leaving AIIMS, but for the foreseeable future, in which they will always be AIIMSonians, no matter the path they choose to follow.

Of all the students I spoke with, Anjali, the latest of five generations of doctors in her family, was the most candid about the ways in which her personal and family privilege – her inherited capital – smoothed her route to AIIMS. Getting into AIIMS was almost inevitable, she said: 'very comfortable circumstances, good schools, the best coaching.' Her family and friends thought she was 'amazing' for getting admission, 'but I've never really had to fight,' she said. And besides, she added, the entrance exam is largely about rote memorization: 'the test doesn't really test how smart you are. It tests how hard-working you can be.' Nor does the admissions process distinguish the potential of future doctors on the basis of anything other than the exam result, allowing for the scenario in which Kapil could win a place at AIIMS despite a professed lack of interest in medicine.

I met Vivek, an intern, at the AIIMSonians picnic¹¹⁴ on a very warm February day. 'The process of selection is completely flawed,' and getting into AIIMS is 'a matter of chance' he said. Vivek felt that the admissions process should include an interview in order to recruit students who would make the best doctors. Dilip, a fourth-year, agreed:

¹¹⁴ A boozy annual event held by the AIIMSonians president at his farmhouse in South Delhi, during which current interns are celebrated and encouraged to join the alumni association.

As far as the exam is concerned, in India, getting selected into a medical or an engineering college is purely on academic basis. They don't look at your CV, extra this or that, work experience...nothing. It's purely academic. So for most families it also becomes a prestige point for their children to get into a prestigious institution. It's like a social... they get respect. That's why they push their students to work hard, get into this college, go to IITs, go to AIIMS, this and that. Not thinking, not realizing that the student might actually not have an aptitude for medicine per se. Just for job security and not actually thinking what the child wants to do. So maybe that's the reason why most students after getting into AIIMS, studying hard, getting into this college, now when they are given the freedom to do whatever they want, they realize, OK, I am not meant to be here, it's not what I want to do. So then they go and do their MBA, do their IAS, etc.

Both Dr B and Dr D, senior faculty members in surgery and community medicine respectively, who had also studied at AIIMS several decades ago, recalled that the entrance exam used to require short narrative answers and was later changed to entirely multiple choice questions. For Dr D, the newer format coupled with the introduction of more reserved seats for lower castes, while not offering a completely level playing field, was an important means through which the student body at AIIMS had become more diverse and less exclusively the domain of students from privileged backgrounds. I explore this theme further in the next chapter.

For Dr B, the format of the current entrance exam as the sole means of admission to AIIMS was informed by the overwhelming level of competition, but also reflected a broader social discomfort with the 'subjective':

Our demand and supply difference is so much, that there is an inherent mistrust of everything. So anything that has got a slight amount of subjectivity is not acceptable. It has to be something that is totally objective, it can be marked, it can be assessed, and there is a number there. I achieve that number, I get it, somebody else who doesn't achieve that number doesn't get it. It's immaterial whether I don't have the skills and somebody else has the skills. I don't have the aptitude, somebody else has the aptitude. Aptitude, skills, these are all subjective terms, so not acceptable in our society as of today.

Dr L, another senior faculty member, strongly opposed the narrow method of the entrance exam and claimed that it had detrimental consequences for the

selection of students: 'The stumbling block to good quality learning is the quality of entrants.' The standard perception of students at AIIMS as India's brightest and best is complicated here by the experience of a faculty member whose job is to create new doctors. Recognizing the shortcomings of the admissions system does not necessarily lead to resolution about an alternative method, however. Dr L agreed that any effort to measure aptitude would be met with charges of biased subjective judgement and could lead to court action by disgruntled parents.

Shankar, in his intern year, agreed that the narrow focus of the admissions process inevitably excluded some talented and highly motivated candidates, but he felt that India's social context precluded any alternatives. His thoughts also confirm a distrust of the apparently subjective and a faith in the objective as an entity that cannot be manipulated and is devoid of social content. Or, to acknowledge the presence of Bourdieu in this chapter, the perceived objectivity of the entrance exam is divorced from the influence of economic, cultural, and social capital on candidates' chances of success.

It's not possible. Some psychological tests can be there, on why are you joining this and all; interviews can be there. But India is very corrupt. So if someone has power, then he can say that give him more marks. It's very subjective. Whereas the system that we have now is more objective so nothing can be done. I mean in the objective, no one can manipulate it. In US they have these recommendation letters and interviews and all. But if it happens in India then it will all be manipulation.

This discourse of trust in 'objective', measurable data takes us back to the imposition of standards through the colonial examination system that were held to be impartial while reflecting the elevation of particular epistemological norms (Kumar 2005). It also intersects with the discourse of 'merit' embedded in concerns about reservation policy, which we will encounter more directly in the next chapter.

Rank, and the life of 'biographical numbers'

Following the entrance exam, candidates are ranked on the basis of their results. In this section, I develop the concept of a 'biographical number' by exploring the potential influence of rank on subjectivity. I situate this intervention as a bridge between the literature on the historical bureaucratic use of number in India, and the work of Charles Stafford (2009) on 'numericized narrative' in contemporary Taiwan. I suggest that interrogating the deceptively complex role of rank illuminates another important dimension of the AIIMS admission process, with consequences that outlive the achievement of 'getting in'.

Using a crude analysis of the 2015 results that employs the most liberal assumptions about the spread between the first and last successful candidates in the general category (i.e. that the 'topper' scored 100% and the last successful candidate scored the cut-off mark of 50%, which never happens), then the average difference between ranks is 0.037%, and the average difference between the number of correct answers of any two successive candidates, even with this unrealistic spread, is 0.07. By extension, given that individual results are calculated to seven decimal places, it is plausible that the smallest difference between ranks 37 (successful) and 38 (unsuccessful) could be one ten millionth of a mark. But to be ranked 38 (as a general category candidate) is to have failed – it is as simple, and as complicated, as that.

Bernard Cohn's (1987) now classic paper on the role of the colonial census in objectifying Indians to themselves and the administration through caste categories is an essential starting point for an exploration of the role and significance of numbers in the emergence of modern India. Cohn inspired several scholars to pursue this line of thought, evolving an argument that, as Norbert Peabody puts it, 'the British collection of numerical data on caste in India was not simply referential but was, in fact, generative' (2001: 821). In a different context but with very similar implications, Ian Hacking's (1985) work on the history of statistics and specifically the concept of 'dynamic nominalism', takes inspiration from Foucault in its interrogation of how new categories of

people are brought into being, or produced, through the very application of new labels. In his article 'Number in the Colonial Imagination' Arjun Appadurai (1993) takes inspiration from both Cohn and Hacking in an effort to extend analysis from colonial classificatory logics to the ways in which quantification was employed as a tool of social control, with visible consequences in contemporary communal violence:

...Though early colonial policies of quantification were utilitarian in design, I would suggest that numbers gradually became more importantly part of the illusion of bureaucratic control and a key to a colonial *imaginaire* in which countable abstractions, both of people and of resources, at every imaginable level and for every conceivable purpose, created the sense of a controllable indigenous reality (1993: 317).

These approaches are crucial to our understanding of the deployment and social life of metrics and measurement in the colonial period. In the case of contemporary exam ranking, I am interested in both its role as a social tool, *and* as a 'biographical number': rank as a form of shorthand for understandings of self and others beyond the simple reflection of academic aptitude that it purports to indicate.

For example, what does it mean for Anjali to say the following during a discussion of her AIIMS experience?

I am definitely very very sure that I am never ever going to get a medal! Like, I know that is beyond me. I am usually in the top 15, but I am like never in the top 5. Being 7th or being 14th doesn't make a difference, to me at least.

Similarly, what knowledge of himself and of others was embedded in the calculation by Purush to leave a college in Jaipur after a few disappointing months, in order to retake the AIIMS entrance exam (to the horror of his parents), based on the following information?

That time I was rank 36 and 11 people were to be selected, from the Scheduled Caste category, I come from that. So 11 people were selected and I was 36... so I thought I should give it one more chance.

Rank has a social life and significance beyond and before AIIMS, compressing into a single number not only a student's most recent exam result, but also her position within a classroom, within the school, within the country; with consequences for personal and family reputation, and embedded assumptions about all that can or cannot be expected of her future. When I raised the role of rank with friends in Delhi, they could often recall numbers from classes at school over twenty years ago. And one in particular described visits by relatives who would demand to know their nephew's rank in maths (and it was always maths), even if they had met just a fortnight ago – a salutation that didn't so much break the ice as ensure an ever deeper freeze. The rank as a numerical repository of so much meaning ensures, as Patricia Jeffery notes in her reflections on grading and assessment, the individualization of both failure and achievement – even though 'the profiles of the successful and the unsuccessful largely reflect the fracture lines of previous privilege, of wealth, language facility and social contacts' (2005: 20).

In nineteenth-century India, Appadurai argues that: 'Numerical tables, figures, and charts allowed the contingency, the sheer narrative clutter of prose descriptions of the colonial landscape, to be domesticated into the abstract, precise, complete, and cool idiom of number' (ibid.: 323). Number, he continues, was a means of 'taming [the] diversity' (ibid.) of the Indian sociocultural landscape. The clean whole integer, the 'cool idiom' of numerical rank assigned to thousands of AIIMS applicants, does similar obfuscatory work in one sense, but it also functions in the opposite way, suggesting diversity where there is homogeneity. Consider five people who have scored 63, 76, 87, 93 and 98 in an examination. A letter grading system might attribute grades C, C, B, A, A, splitting the five into three categories and grouping students accordingly. The ranking system by contrast ruthlessly individualizes, precluding shared identity – five people are five separate identities. Ranking thus acts as a tool of management through deception, suggesting a warranted differentiation of achievement that disguises the homogeneity of marks among top-ranked students, and implying that those who miss the cut-off lack the necessary aptitude to study at AIIMS. As a former director of AIIMS noted when we spoke

about the factors that set AIIMS apart from other medical colleges, this is far from true: 'it is not only the 35 who are good, that join AIIMS – the 3500 who are after this are equally good candidates.'

Sociologist Satish Deshpande writes of ranked results that, 'the obsessively continuous scale suddenly transforms into a dichotomy with the guillotine of the cut-off point creating two internally homogeneous but mutually exclusive groups' one considered 'meritorious' and the other 'without merit' (2006: 2442). Given that the cut-off is determined by the number of places, so is the number of so-called 'meritorious' students. The exam, Deshpande argues, 'is only a means to identify who they will be.' He continues:

...it is not necessary to explain what meaning the differentiations carry. More accurately, as long as they are present, it is permissible to simply assume that the differentiations mean whatever they are supposed to mean. This is the underlying system that, under the pressure of large numbers of aspirants, produces the arcane world of third decimal point differences and cut-offs that are accepted as justifying large claims about the presence or absence of merit. (2006: 2442)

'Merit' is both bestowed and withheld by rank, and is inextricable from a discourse of caste and the politics of affirmative action, as Ajantha Subramanian (2015) has shown in her work on the Indian Institute of Technology Madras, and which I explore at AIIMS in chapter 5.

The exam, and therefore rank, have two clear social functions in Deshpande's understanding. Firstly, 'to produce or elicit evidence of inequality from the candidates' and secondly, and by extension, 'to provide an ideologically defensible method of saying "No" to large numbers' (2006: 2442). Deshpande adds that the top institutions 'cheat' by setting higher than reasonable entrance standards. Given that demand ensures enough people will reach them, the institution can then 'free ride' on the assumption that students will require little additional intervention to pass the final exams (2013a: 38). As we will see in chapter 5, however, this attitude can lead to the harmful neglect of students, particularly those with weaker English, who *are* in need of extra support.

While India's scale can only be matched by China, Bourdieu considers a very similar phenomenon from the perspective of the cultural capital bestowed by success in the highly competitive French *concours*, or competitive recruitment examinations, which:

...out of the continuum of infinitesimal differences between performances, produces sharp, absolute, lasting differences, such as that which separates the last successful candidate from the first unsuccessful one, and institutes an essential difference between the official recognized, guaranteed competence and simple cultural capital, which is constantly required to prove itself. In this case, one sees clearly the performative magic of the power of instituting, the power to show forth and secure belief or, in a word, to impose recognition. (1986: 88)

These contemporary reflections feed back into Appadurai's work on numbers in the colonial context, about which he stresses that 'it is not so much that numbers did not serve a straightforward referential purpose in colonial pragmatics...but that this referential purpose was often not so important as the *rhetorical purpose*' (320, my emphasis). Considering the rhetorical purpose of a rank leads me to couple this analysis with an enquiry into its subjective content at AIIMS via which I posit the nascent concept of a 'biographical number'.

Following Charles Stafford's work on 'numerical lives' in Taiwan, I want to consider how rank might be used as a means of 'narrating the self numerically' (2009: 7). Reflecting on the apparent wariness of anthropology to tackle the lived experience of numbers, Stafford notes the tendency to view numbers as reductionist (we balk at the idea of being 'reduced to a number'), at odds with imagination and the narrative description inherent in autobiography (ibid.: 1). I would agree that this is how many of us within anthropology, and I include myself, are accustomed to apprehend numbers. With suspicion of the neat simplicity they impose upon a messy world. And often with good reason, because statistics do have a tendency, as Appadurai puts it, to 'flatten and enclose' (1993: 334). Challenging the sometimes suspicious hygiene of number – revealing the myriad social, cultural, political influences digested by digits – is a

valuable endeavour.¹¹⁵ It is, after all, what I attempt to do in this thesis by asking what it means for AIIMS to be understood as the ‘best’, or, in keeping with the current discussion, to be ranked number one – to be the ‘topper’ among Indian medical colleges.

My simultaneous effort, however, to extend Appadurai’s work in the direction of Charles Stafford’s, is to recognize that some numbers have *meaning* for those to whom they are applied – that as well as words, *numbers*, including rank even after we have revealed its empirical absurdity, work upon subjectivity. Guyer and colleagues (2010) discuss the slow evolution of the anthropology of numbers – as distinct from the small sub-field of ethno-mathematics – beginning with its instigation by Thomas Crump and his interest in ‘the lore of numbers’ (1990: 146) stimulated by long-term fieldwork experiences in Japan. They remark in detail on the various disciplinary approaches to numbers – from the obvious mathematics, to semiotics and its ideas about mathematical grammars of meaning, philosophy, and cognitive psychology – that might inform an anthropological approach to human relationships with numbers in the ethnographic present.

What do ordinary people do when they are drawn into emotional states as well as cognitive manoeuvres by numerical terms? Once number moves out of technical life and into domains of culture and power, quantitative anthropology becomes no longer about how we should quantify the world, but about how *people* inhabit worlds that they already apprehend numerically. (Guyer et al. 2010: 37, original emphasis)

My thoughts about biographical number, then, need not be confined to the students in this thesis. Biology provides us all with (auto)biographical numbers – think age, weight, height – all dimensions imbued with sociocultural meanings that influence the way we think about ourselves and others. The *Aadhar* scheme, administrated by the Unique Identification Authority of India, is a recent technological intervention that enfolds an individual’s biometric data within

¹¹⁵ In this spirit, the WHO named its strategy for reviewing maternal deaths ‘Beyond the Numbers’ (http://www.who.int/maternal_child_adolescent/documents/9241591838/en/, accessed 12/06/16). And see Gutschow (2016) for an example of how ethnography can contribute to this effort in an Indian context.

twelve randomly generated digits, acting as a digital authenticator of identity (see Cohen 2012, and Rao 2013 for two different analyses of this number and its implications). Rank operates differently, however, as a number that is attributed in response to an exam result, and which inescapably, and enduringly, encodes an individual's place in a hierarchy¹¹⁶. This prompts a question about whether the incorporation of rank into (auto)biographical narrative might be understood as a strategy for taking an inescapable – public – signifier and imbuing it with personal meaning.

Reflecting on the life of his Taiwanese interlocutor, Mrs Chen, Stafford writes:

It is interesting...that although social scientists might think of numbers primarily as a way of aggregating the (otherwise unmanageably diverse) experiences of individuals, for Mrs Chen numbers are one way of differentiating *her* story from everybody else's. To put this differently, although numbers appear to aggregate things, restricting the scope for what can be said (because they simply tell us 'how things are' once everything is added up), in reality numbers may equally help *disaggregate* individuals from collectives and may also help them to see (and to say) something new about their lives. (2009: 7, original emphasis)

This self-identification through number is not necessarily positive. In *RevolutionTwenty20* (2011) Chetan Bhagat's Gopal is ranked 52,043 of almost 500,000 candidates, a position that informs his self-definition as a 'loser' despite having scored better than hundreds of thousands of others. Karthika, a junior resident in community medicine, explained to me how personal rank maps onto the prestige ranking of particular medical fields and laughed at her prospects of securing a coveted place on an internal medicine course because that would have required a top ten rank following the postgraduate exam. And that, she confidently stated, was 'not possible'. Here, rank informs a self-perception that is considered indisputable and quite possibly immutable. A senior resident at AIIMS recalled falling short of the cut-off for the Institute's MBBS by two ranks over ten years earlier, and a public health professional immediately told me the

¹¹⁶ Although rank is not entirely abstracted from biology in the views of those who still consider intellectual 'merit' innate to upper castes and rare among SC/STs in particular.

exact number of ranks by which he had missed a place at AIIMS a decade ago. These particular memories were not recalled with a sense of regret, more commonly with a wry smile. We should not assume that an AIIMS rank below the cut-off threatens an individual's sense of self-worth in perpetuity; it may, however, remain a feature of an autobiography, reflecting its consequences for subjectivity and experience.

Nor is rank a necessarily stable identity. It shifts according to circumstances. As Azam explained:

...when everybody reaches here, the very first two-three months, it will be like everybody, almost all the students are competitive, because whoever reaches AIIMS was a topper of its batch. I was a topper of my school, then in the coaching institute also I was the guy who got the best result out of my class, even though 10-15 students got admission to AIIMS, and when we come over here we feel like we should be competitive, [because] it's like a dream of the whole nation.

There were other reasons for ranks to shift around. Mihir's psychological argument demonstrates the power of rank to impose differentiated identities on candidates with virtually identical marks, and also confirms the exclusion of candidates in reserved categories from what is considered truly 'meritorious' competition:

You see even when you analyze our rank list, there are around 35 seats for the general category. Among the 35 seats you will see that the people who are in the top ten to 15 ranks, they are generally those sort of people who had a bit of talent for solving questions or reading a particular thing and extracting...so they didn't work hard that much to get into AIIMS. But the people who are from 30 to 35, generally those are the ones who by the skin of their teeth have got here, so when in our first [internal exams] you see the rank list, the toppers are those who were [ranked] 30 to 35 [in the entrance exam]. They are in the habit of working hard from the start. Those are the people who generally come here and then are on top because they know they can study for six hours a day, or eight hours, whatever is required. We aren't in the habit of working that hard, at least in academics, so we don't take it seriously.

Reflecting the complex and interrelational nature of biography, it is not only one's own rank that has the power to influence identity, self-perception, and how one is perceived by others. Nor is this influence static or necessarily confined within a single generation. Recall, for instance, the story of Rahul, whose trajectory towards medicine was largely informed by his mother having missed the cut-off for acceptance into medical college by just eleven marks. Rank-by-association also ripples beyond the individual to inform other relationships. Anjali had dated the previous year's AIIMS postgraduate topper for several months, and smiled as she told me of her parents' disappointment when the relationship with someone they had considered so suitable for their daughter ended.

Stafford writes of the various ways in which Mrs Chen's life is permeated by numbers: the income from her tea stall becomes a narrative device connecting various parts of her numericized life, including gambling, religious worship, and fortune telling. Such a perspective suggests a rich seam of potential future research into numbers in Indian lives more broadly, departing from an analysis of an AIIMS exam rank as a form of (auto)biographical exposition by students who try to live up to, improve, or defy their rank, as the case may be.

*

Our students have made it into AIIMS. In this chapter I have explored some of the mechanisms – historical and contemporary – that have contributed to these particular young people, and not others, being invited through the gates, highlighting where applicable the relevance of Bourdieu's theory of capital to this process. I have also posited the concept of a 'biographical number' based on an analysis of the way in which exam rankings impose a false differentiation upon students, with consequences for personal understandings of self and others.

In the next chapter I look at the consequences of our students' success by following them through the gates and exploring their experiences of AIIMS as an

occasionally liminal space, with particular attention to caste and a narrative of freedom.

CHAPTER 5. 'FREEDOM': BEING IN

The thing is, AIIMS is not a hospital or an island in isolation. It's like a whole society, so already what are the problems in this society as a whole are ingrained in AIIMS also.

– Purush, intern, 10/3/15

AIIMS is an island – people don't relate to the outer world.

– Purush, intern, 10/3/15

In the previous chapter, I traced the journeys of our students into AIIMS, taking into account the social and educational structures that enable the success of some applicants and hinder that of others. In this chapter, I step inside the gates to explore the ways in which student life at AIIMS informs my central thesis that the institution is both insulated from and permeated by the norms of contemporary Indian social life. I take Purush's comments above as a departure point from which to illuminate how students experience AIIMS as a liminal yet relational space – an island that can only be experienced in a temporary and illusory sense, given its undeniable attachment to the mainland.

I begin my approach to these themes with an enquiry into whether, and how, the ferocity of competition for admission to AIIMS manifests among those students who make it through the gates. I continue by scrutinizing the discourse of 'freedom' used by many students to characterize the personal and social dimensions of their time at AIIMS. The lens through which I go on to explore this point is that of caste-based reserved seats for students at the Institute. The politics of reservations act to counter any vision of AIIMS as an unblemished institution transcending social structures in its pursuit of medical science, revealing the institution, and indeed medicine itself, as not set-apart from, but rather emblematic of the social unease characteristic of modern India (Tharu et al. 2007).

I did not, as it were, go looking for caste at AIIMS. Nor did I anticipate that a chapter of my thesis would be about reservations; of all the themes in my thesis, it was the often spectral presence of reservation-based difference at

AIIMS that revealed itself almost entirely through the writing process. Without denying the analytical salience of other determinants of student experiences at AIIMS (gender, class, or language, for example, all of which intersect with each other and with caste), it is the simultaneous centrality and obfuscation of the dynamics of reservations on campus that I contend make their scrutiny particularly urgent. Throughout the chapter, I hold in mind the following words of Sarah Pinto (2008), and attempt to do them at least partial justice:

How can we account...for overdetermined modes of othering like 'caste' and the ways the very imagination of such entities as bounded is at once part of the discursive craftings of modernity and also very real, very embodied, very everyday? We begin, I would like to propose, by considering how such clichés and stagnancies play into and through other (and similar) uses and them. 'Untouchability' becomes less about 'hierarchy' and more about circulating diacritics that frame the contemporary subject of intervention. (24)

'The cream of people'

From where I was sitting in Anjali's small single room in the women's hostel, I couldn't see what she was pointing to. 'Look in the mirror,' she suggested. When I did so, I saw a list of words written in green pen reflected from the wall behind me. The mirror writing made little difference to my comprehension – even when I twisted to see the long list of revision topics made legible, many of the scientific terms remained mysterious. The list was a visual reminder of the looming final professional exams ('profs') for MBBS students that take place in October and December of the fourth year, before the internship. A sense of dread begins to mount during the summer that follows the comparatively relaxed third year, which is free of major exams. In Anjali's view, however, that dread, and the pressure it expressed, was not evenly distributed. 'There are two types of students,' she said. 'Competers and coasters.'

In response to my questions about competition, students tended to identify different personality types, rather than describing a generalized institutional

culture. For many students, AIIMS was much *less* competitive than they had anticipated given its reputation, and their experience of the admissions process. The level of competition, the particular skills and knowledge tested by the entrance exam, and the place of AIIMS in the popular imagination, combined to conjure an imagined cohort of ‘super students’ who spent every waking moment at their desks in an effort to outdo all others. This expectation was, on the whole, confounded on arrival.

‘It was a pretty great experience, but not as I expected,’ Shyam reflected. ‘I expected this to be a college full of nerds, which it turns out not to be!’

Rahul expanded on the same sentiment:

It is different actually. You come here expecting like, it’s AIIMS, everyone will be just studying and studying. Because you are thinking it’s a top medical college, top hospital of the country and everyone will be just into books and everyone will be wearing big thick specs! But it definitely was not that. I have been here for three years and it was completely different from what I thought.

Anjali spoke of a degree of disappointment in the intellectual standard of her peers, but acknowledged that this had its advantages too: ‘I mean it would have been difficult if everyone was as brilliant as I had hoped they were...’

Not everyone agreed that competitive instincts were discarded with relief on arrival at AIIMS. Neha said that people differed in their approaches to studying and assessment:

I guess it depends on your personality. Like some of my friends, they are still in that mode like we used to be in school. They are very competitive and they study every day, they take exams very seriously. But I guess half of us, like me, we are very relaxed.

Vivek put these differences down to personal ambition: ‘there are two extremes of students at AIIMS. Some who just want to live a life and some who really want to do something. So competition still exists.’ For Deepak, competition was inevitable and not assumed to be negative:

There has to be competition. There has to be and it's the very essence of being in AIIMS because AIIMS caters to, I would say 0.1% of the population, they are the cream of people. Sometimes it gets very harsh. Like people stop talking to one another just because he is reading too much, or like that. But not everybody. You can say two-three people, or five people in a batch can be like this. But competition is healthy.

For Anjali, the social consequences of these varying degrees of competition manifested through a greater number of intra-batch rather than inter-batch friendships:

You will probably have just two or three friends in your own batch and like four or five in the batch above and in the batch below. Because that's the route of information transfer – you wouldn't get to know where to study, what to study from the person sitting next to you. Because he wants to get more marks than you do.

In my discussion of rank and biographical number in the previous chapter, I cited Mihir's explanation of how students' ranks on entry shift around following internal exams. His thoughts are also interesting from the perspective of competition:

You see even when you analyze our rank list, there are around 35 seats for General Category. Among the 35 seats you will see that the people who are in the top ten to 15 ranks, they are generally those sort of people who had a bit of talent for solving questions or reading a particular thing and extracting...so they didn't work hard that much to get into AIIMS. But the people who are from 30 to 35, generally those are the ones who by the skin of their teeth have got here, so when in our first profs you see the rank list, the toppers are those who were [ranked] 30 to 35 [in the entrance exam]. *They* are in the habit of working hard from the start. *We* aren't in the habit of working that hard, at least in academics, so we don't take it seriously. Those are the people who generally come here and then are on top because they know they can study for six hours a day, or eight hours, whatever is required (my emphasis).

We are given a glimpse here into the biographical content of certain numbers from Mihir's perspective. Those ranked 1-15 at admission – including Mihir, we are indirectly informed – are considered to possess particular gifts that allowed them to perform extremely well at the exam without excessive exertion. Those

ranked 30-35, however, only make it into AIIMS 'by the skin of their teeth' after great exertion, which they are conditioned to continue during their MBBS. The results of the first profs that Mihir cites suggest that some students internalize the association between rank and exertion, even if rank 30 trails rank three by a miniscule fraction of a mark. Such rationalization feeds a discourse of merit that obscures accumulated social and cultural capital behind assertions of hard work, application, and natural aptitude (Deshpande 2006, 2013; Galanter 1984; Subramanian 2015). To remain with biographical numbers for a moment, a rank between 35-70 therefore implies that a student has a reserved seat at AIIMS, emptying the number of merit in the eyes of others and replacing it with political intervention. I pursue this line of thought below.

Dilip also noted the shifting of ranks, pointing out that those with top All India ranks didn't necessarily rank highest in the AIIMS internal exams. His explanation spoke less to an idea of innate talent, however, than to a flexible appellation of 'brightness' which, I would suggest, stems from the arbitrary nature of the exam rankings, as discussed in chapter 4: 'So it's not that the child who was bright at the beginning, when he came to the college, stays so through the course.'

Dilip attributed a decline in 'the zeal to study' to a sense of having secured good future prospects simply by getting into the Institute: 'no career tension now; we can do whatever we want.' And in Azam's experience, students arrived at AIIMS conditioned to compete, but this instinct waned after the first semester as people realised they weren't necessarily competing over the same future:

Actually first when everybody reaches here, the very first two-three months, it will be like everybody, almost all the students are competitive, because whoever reaches AIIMS was a topper of its batch. I was a topper of my school, then in the coaching institute also I was the guy who got the best result out of my class, even though 10-15 students got admission to AIIMS, and when we come over here we feel like we should be competitive, it's like a dream of the whole nation. But after that we realise that the person who is sitting next to us won't be having the same profession in the future. Like the person sitting next to me will be a paediatrician, I will be a gynaecologist, radiologist, something like that.

So after we realised that, we help each other rather than competing. After that we mature, we understand.

In the background of these conversations about competition, and sometimes explicitly acknowledged by students, was the spectre of the postgraduate entrance exams which face all those who plan to continue medical training. Krish, a fourth-year student, anticipated a more competitive environment as he approached the end of the MBBS, particularly during the internship year (see chapter 7).

Azam's comment above about maturing was echoed by others as they reflected on their experiences at AIIMS. The discussion that follows looks at how a discourse of freedom speaks to a view of AIIMS as a comparatively unique liminal environment for many of its young students.

'I think AIIMS is like heaven': on freedom

At the time of my fieldwork, attendance at lectures by MBBS students had only recently been made compulsory by the academic administration, and in the eyes of the fourth-year students I spoke with, the ruling had yet to be taken particularly seriously.¹¹⁷ The choice whether or not to attend classes was considered part of the 'freedom' that made life at AIIMS so appealing among students. The lack of hostel curfew was the other crucial factor, as Krish explained:

We have 100% freedom in AIIMS, compared to other medical colleges and all; we are free to do anything. In our hostel also we can come any time, we can leave any time, we can do anything. No one is there to control. It's a very good opportunity for people...like if I want to study, I can study 100%, if I don't want to study, I can enjoy 100%. In AIIMS that's like that. We can study freely, we can enjoy freely, we can do anything freely. I think AIIMS is like heaven.

¹¹⁷ There is history here. In the 1970s, T.N. Madan found that compulsory attendance had been suspended at the demand of students, and subsequently reinstated (1980: 82). Presumably, then, at some point it was suspended once again.

Anjali added the quality of facilities to the list of things that set AIIMS apart:

This hostel is like the best hostel in the whole of Delhi, because I can go out at 2am in the morning in my car and no one will ask me anything about it. While even in Delhi University, arts students, they cannot leave after 7-8...and I can do pretty much anything I want to. Besides that, the facilities are great. I have a room with an AC and a heater, and a fridge, which no one else gets.¹¹⁸ And then there was no attendance, when I just came...now it's changed, now the attendance has become compulsory. But when I came, like my seniors had attendances of 23%. So yeah, they were pretty much free to do anything with their lives. They didn't even have to be medical students! The independence and the freedom is overwhelming.

The celebratory nature of the talk about freedom at AIIMS is heightened when compared with 'timepass' as studied by Craig Jeffrey (2010) in his work with young lower-middle class men in Meerut. Among students at a college where standards of teaching and infrastructure have declined in recent years, 'timepass' is imbued with frustration and melancholia, and is used 'to signal their removal from spaces of relative "modernity"' (81). Students at AIIMS, conversely, experience the exhilaration of an existence at the heart of Indian modernity, both in terms of urban life in South Delhi, and as part of the country's most prestigious medical community. 'Timepass' in Meerut is about killing time, while 'freedom' at AIIMS is about not wanting it to end.

A comparative perspective was central to many students' descriptions of AIIMS. Being aware of the experiences of friends at other colleges fed a perception of AIIMS as a unique space insulated from external realities. AIIMS is then perhaps better understood as a relational space, considered special precisely in comparison with other institutions that are perceived as lacking in

¹¹⁸ The film *Placebo* (2015, dir. Kumar) gives an insight into hostel living at AIIMS, where peeling paint is visible in the same room as a Mac desktop computer. For comparison, see Dandekar's study of students at a government medical college in Maharashtra who spoke of gratitude for their own iron cot (without a mattress), and a reliable water and electricity supply (2013: 126). One student reported cycling 20km to college each day because his family could not afford the subsidized hostel fee. Also see Jeffrey (2010: 75-78) for an account of poor infrastructure at a college in Meerut.

various ways.¹¹⁹ This is one sense in which AIIMS comes to be considered an island by virtue of a firm attachment to the mainland.

Karan had left AIIMS a year before I arrived, and had spent several months working at a community health centre in the Himalayas of Uttarakhand. We met on one of his periodic visits to AIIMS, and he spoke earnestly of his approval of the Institute's onus on student independence:

AIIMS is the most liberal institute in India. You have choice. If you want to go this path it's your choice. So no one is going to force you. If you want to learn medicine, you can learn. If you don't want to learn, no need to. It's your call. You have to decide where you have to reach, what you have to achieve.

These descriptions of a 'liberal institute' in which a student is free to learn or not according to their own wishes, feel at odds with the descriptions of the pressure and competition that surrounds the AIIMS admission process. This reality within the gates, in which students feel little structural compulsion to study, sheds further light on the consequences of an entrance exam that neither asks about an applicant's reasons for studying medicine, nor enquires into their potential beyond exam success. It also adds weight to Satish Deshpande's argument that such enormous demand for higher education allows elite institutions to 'cheat' by setting 'higher than reasonable entrance standards', which ensures that students are virtually guaranteed to pass their final exams with a minimum of institutional support (2013b: 38).¹²⁰ For some students, 'freedom' manifests as institutional neglect, with occasionally tragic consequences, as we will see below.

Anjali noted that the degree of independence students had at AIIMS could be 'overwhelming,' which hints that while a discourse of freedom pervaded student descriptions of AIIMS, it was not always celebrated. Pursuing social and academic opportunities was a challenge for a third-year student I spoke with, for example, who described himself as 'reclusive'. Rahul, the fourth-year from

¹¹⁹ See chapter 7 for a discussion of how value is determined through comparison.

¹²⁰ Contrast this with the comment by a faculty member in Madan's study, that 'the very strict admissions procedures' allowed for pedagogical experiments on 'the finest guinea pigs you could get' (1980: 79).

Himachal Pradesh, told me about spending the first year avoiding parties and social situations he found intimidating. Further, the 'freedom' that AIIMS offers students not to study, suggests conversely that a high quotient of self-direction is required to extract the greatest benefit from the MBBS. Not all students arrive equipped with the resources this approach demands. As I discuss in chapter 6, several students lamented variable standards of teaching at AIIMS, and the reluctance of some faculty to engage with undergraduates. Navigating the often hierarchical relationships that differentiate faculty from students, and students from each other, demands a confidence that not all students possess and which may depend as much on education and class habitus as on a gregarious personality. I expand on this in the discussion of reservations below.

AIIMS as a liminal space

The caveats above notwithstanding, several students extended the freedom discourse further and credited the AIIMS environment with facilitating their personal development and growth into adulthood:

That was extraordinary for me. You know I belong to a very narrow, say orthodox family. I came out of my home and I really enjoyed it. And rather, I have evolved here. I have evolved at AIIMS. I was this tiny, and I have evolved into a human being. It really nurtured my perspective. – Karan

AIIMS moulded me completely. Before coming here I was a different guy. I never used to think about anything else, I was a self-centred guy. I was not a bit worried about the world, about what's going on around me. But here I have improved. When I was at home, I was in my cocoon. But after coming here I saw the world, where I am and where the world is and where the people are. I saw YouTube videos, learnt what I am...I learnt everything from YouTube. Dance, English...I used to dance, during our fest.¹²¹ This is because I saw people around me, they are better than me.

¹²¹ Pulse, the annual student-organised festival on campus, is considered an important means of 'enrichment' as Neha and Priya put it. Organized by third-years, Pulse is a serious business, attracting corporate sponsorship and allegedly offering a more literal means of enrichment to students in key positions. Pulse offers opportunities to be involved in the creative and performance side of P-Wave, the much anticipated opening show, as well as in management and administration tasks. However, the 2007 Thorat Report into caste discrimination at AIIMS cited exclusion from participation in Pulse as one way in which this manifested. While students

So it gives like a competitive environment. AIIMS is like very...it has changed my personality a lot for the better. – Dhananjay

Both Karan and Dhananjay described a world at AIIMS that was simultaneously a great expansion of that which they previously inhabited, and also sufficiently removed from that reality to allow them to explore opportunities, and to ‘evolve’, in Karan’s words. From this perspective, then, AIIMS appears as a liminal environment for students – a space where norms, while not absent, are less rigid, less determining of who a person is allowed to be and more accommodating of who a person might choose to become.

While Victor Turner’s (1967) original description of liminality pertained to coming of age initiation rites among the Ndembu in Zambia, contemporary scholars have been keen to demonstrate the relevance of the concept in a variety of contexts (see Horvath et al. 2015 for recent examples).¹²² Liminality usually marks a period of transition from one state to another¹²³ – in our case, young people becoming adults, and students becoming doctors. Understood as neophytes, our students exist ‘betwixt and between all the recognized fixed points in space-time of structural classification.’ (Turner 1967: 97). In this ‘interstructural’ position (ibid.: 99), the subject is made ‘structurally, if not physically, “invisible”’ (ibid.: 95), present in ‘a realm of pure possibility whence novel configurations of ideas and relations may arise’ (ibid.: 97).

...Neophytes are withdrawn from their structural positions and consequently from the values, norms, sentiments, and techniques associated with those positions. They are also divested of their previous habits of thought, feeling, and action. During the liminal period, neophytes are alternately forced and encouraged to think about their society, their cosmos, and the powers that generate and sustain them. Liminality may partly be described as a stage of reflection. (Ibid.:105)

did not raise this as an issue with me, this is not to say that incidents of exclusion may not still occur.

¹²² Also see Thomassen (2015) for an historical overview of the use of ‘liminality’ in anthropology, beginning with van Gennep’s Rites of Passage from 1909 (1961). Szokolczai (2015) discusses liminality in philosophical thought in the same volume.

¹²³ See Szokolczai (1998) for a consideration of modernity as a state of permanent liminality.

Students described various freedoms afforded them at AIIMS that they had not previously encountered at home or heard of at other institutions – whether freedom of movement, self-directed learning, or the relaxation of taboos around socializing and sex. Any discussion of sex was indirect. It was alluded to by noting that female students had unrestricted access to the male hostels, with some taking up semi-permanent residence. Or when Ashish told me that he had to buy condoms for a senior student during the month of ‘ragging’ that greets new MBBS arrivals.¹²⁴ I did not spend sufficient time with students in the hostels to explore this further, but the dynamics of sex on campus is another of the many research themes deserving future attention.

Given what we know of the admissions process, students’ embrace of these freedoms appears a logical reclamation of an adolescence suspended during the competition for a place at AIIMS. In some ways, an AIIMS student appears similar to her peer at any university in the West, with a life organized as much around socializing and extracurricular pursuits as it is around academic demands. The sense of liminality is, I would suggest, more pronounced, and perhaps more conscious, at AIIMS, however, given how dramatically these new freedoms will be curtailed for many students on graduation. A graduate in the West may feel her freedom constrained by a precarious job market and the cost of living, but personal liberties pertaining to sexuality, freedom of movement, and life choices remain, for the majority, intact. For many middle class students at AIIMS, particularly (although not exclusively) those who will remain in India following graduation, the personal freedoms experienced (whether through participation or observation) during their undergraduate years are likely to prove an aberration in an otherwise deeply conservative society (Abraham 2002). I return to this thought at the end of the chapter.

Below, I move on to discuss reservations at AIIMS, complicating an understanding of the MBBS as a liminal period, both in time and space. In his original description, Turner states that while a strong social structure is imposed on the liminal period through the authority of instructors over neophytes, the

¹²⁴ Ragging has been officially banned on Indian university campuses since 2009. It seems to continue at AIIMS, albeit in a milder form than previously (see *Placebo* 2015, dir. Kumar).

liminal group itself, composed of people, whose ‘condition is one of ambiguity and paradox, a confusion of all the customary categories’ (ibid.: 97), ‘is a community or comity of comrades and not a structure of hierarchically arrayed positions’ (ibid.:100). To the extent that a shared AIIMSonian identity endures beyond graduation, this is certainly true. However, for the very same reasons that AIIMS as a whole cannot be understood as entirely insulated, the student body cannot be understood as an unassailable liminal entity. The politics and experience of reservations is an unavoidable case in point, presenting examples of both the possibility and limitation of AIIMS as a liminal space.

‘The coasters’: the social life of reservations at AIIMS

At the beginning of this chapter, Anjali described the student body in terms of ‘competers and coasters.’ With a sense of how competition fluctuates and is differently interpreted at AIIMS, I look back now at Anjali’s description to ask, who are the ‘coasters’? Notably absent from Mihir’s account of the biographical content of, and dynamics between, ranks 1-35, they are, in Anjali’s words, ‘the ones who are always relaxed’; those who study after finishing a movie, or a game of football. Either, she explained, these are students who intend to leave medicine for an alternative career, or they are those ‘who don’t have to bother because they know they’ve already got a PG [postgraduate] place.’ Such is one method of identifying peers who are at AIIMS ‘on reservation’.¹²⁵

A history of protest

In early April 2006, a group of students at Delhi’s University College of Medical Sciences (UCMS) held a meeting to discuss the announcement by Human Resource Development Minister Arjun Singh that the Congress-led United Progressive Alliance (UPA) government intended to introduce a 27% quota of

¹²⁵ The AIIMS entrance exam pass mark is 50% for general category students, 45% for the OBC category, and 40% for the SC/ST category. Although as we have seen in chapter 4, those admitted to AIIMS all have very similar marks in the high 90s.

reserved seats for members of Other Backward Classes (OBCs) at centrally-funded institutes of higher education. Combined with the existing 22.5% quota of reserved seats for SC/ST students mandated during the original drafting of the Constitution, the new policy meant the reservation of 50% of seats for those from historically disadvantaged communities. Following their initial meeting, the UCMS students allied with peers from four other medical colleges – MAMC, Lady Hardinge, Vardhman Mahavir Medical College (VMMC), and AIIMS – to establish a forum they called Youth for Equality (YFE).¹²⁶ By late May, YFE was known nationwide for its central role in the protests that demanded the proposed OBC quota be scrapped and that the existing policy providing reservations for Scheduled Caste and Scheduled Tribe (SC/ST) students also be reviewed. The agitation led to a nineteen-day medical strike in several cities, supported by the Indian Medical Association. AIIMS became the national hub of the protest, referred to as '*Kranti Chowk*' (Revolution Square).

AIIMS hosted a rolling hunger-strike by medical students that led to at least one student being admitted to the hospital, where emergency services were compromised as part of the protest (Hasan 2009: 103; Venkatesan 2010). The strike was supported by 'the corporate sector, traders associations, chambers of commerce, industry lobbies, the Indian Medical Association' and voices in the media (Hasan 2009: 103): an editorial in *The Hindustan Times* lauded medical students for their 'heroic role in resisting the irrational government policy of enforcing quotas for the OBCs in institutions of higher learning' (ibid.). The anti-reservation agitation ended on the 3rd of June 2006, when the Supreme Court stayed the reservation law in order to submit it to judicial review (ibid.: 111). The law was implemented in 2008, with amendments that expanded the number of 'general category' seats to maintain the existing proportion, and rendered the 'creamy layer', or most affluent, of the OBCs ineligible (Venkatesan 2010).¹²⁷

¹²⁶ <http://www.youthforequality.com/about-us/history.aspx> [accessed 4 Dec 2015].

¹²⁷ Not all agree with the exclusion of the more affluent OBCs from the reservation policy. Deshpande, for example, argues that such a decision empties 'the social' of meaning, if discrimination is presumed to dissipate with the accumulation of wealth (2013b: 37). Also see Hasan (2009) for a discussion of historical and contemporary debates over the use of caste rather

By the time of the protests in 2006, reservations had been in place in one form or another in parts of India for a hundred years, beginning under the influence of social reform movements in Maharashtra. An agreement tied to the 1932 Poona Pact¹²⁸ officially pronounced ‘that Untouchables were both a distinctive and an oppressed segment of the Indian population’, and it was this agreement that formed ‘the basis upon which a huge machinery of institutional privilege was erected so as to right historical wrongs’ (Mendelsohn & Vicziany 1998: 14), or what Marc Galanter (1984) has referred to as ‘compensatory discrimination’.

The Dalit leader B.R. Ambedkar was unhappy about not having achieved separate electorates for India’s most oppressed groups, which he considered a more empowering mechanism than the reservation system. I heard an echo of this view at AIIMS. ‘Reservation is a bourgeois answer to revolution,’ Dr N said. He expanded in Gramscian terms that the ruling elite was able to maintain its hegemony by co-opting lower caste groups and offering them a share of power, small enough to pose no real threat to the existing order (see Deshpande 2015 on the continued domination of powerful institutions by upper castes). Paradoxically, he said, reservations act to ‘stabilise an oppressive system’.¹²⁹

Ambedkar also chaired the Constitution Drafting Committee that enshrined the following in Article 46 of the Constitution’s Directive Principles:

The State shall promote with special care the educational and economic interests of the weaker sections of the people, and, in particular, of the Scheduled Castes and the Scheduled Tribes, and shall protect them from social injustice and all forms of exploitation. (In Hasan 2009: 4)

On the rationale behind reservations, Deshpande notes that:

than economic class to determine eligibility for reservations, and in particular the detrimental consequences this has for Muslims, who continue to be disproportionately deprived in India.

¹²⁸ The Poona Pact ensured increased representation for SC/STs, although Gandhi’s hunger strike forced the Dalit leader B.R. Ambedkar to relinquish an agreement on the creation of separate electorates (Deshpande 2013: 27). See B. Singh (2015: 21–32) on the enduring sociopolitical nuances of categorical definitions of caste and tribe categories.

¹²⁹ See Tharu et al. (2007) on reasons for why, despite having little overall impact on reducing inequality, reservations have become a central staging ground for debates about the contemporary polity.

The twin goals confronting the nation-building project were not only the demands to alleviate the sufferings of the lower castes but also to reduce the power of the privileged elite and redistribute the benefits that they had monopolized. Reservations were thought to be one of the most effective ways of helping to break the social exclusiveness of the public sphere. Politically, it came to be seen as evidence that the state cared for the communities that were discriminated and excluded. (2013b: 37)

The Mandal Commission

The Mandal Commission (so-called for its chairman, B.P. Mandal) was established in 1979 by the Janata Party government led by Morarji Desai, with a mandate to ‘identify the socially or educationally backward’. The report recommended extending reservations in central government services from 27% to 50%, to include OBCs together with the existing SC/ST quota. It was submitted in 1980, but was ignored by then Prime Minister Indira Gandhi, and her son and heir Rajiv, neither of whom had an appetite for further political turbulence in the wake of the Emergency that had been imposed on the nation by the prime minister between 1975–77. Rajiv Gandhi is reported to have said in response to a question about the report: ‘It’s a can of worms; I won’t touch it’ (cited in Hasan 2009: 87). It was the non-Congress coalition government of V.P. Singh, ten years later in 1990, that implemented OBC reservations in an action popularly known as ‘Mandal I’ (Hassan 2009: 87).

The reaction to the extension of central reservations to OBCs was dramatic as protestors took to the streets across North India¹³⁰. Whereas the existing SC/ST reservations had been understood as a means to improve equality of opportunity for undeniably oppressed groups, extending reservations to OBCs posed an unprecedented threat to the status quo, adding momentum to the new subaltern politics that were already underway (Jaffrelot 2002). The change in policy occurred amidst rising levels of education and greater competition for jobs, particularly the prized positions in government service that represented

¹³⁰ The reaction to reservations in South India tends to be more muted (though not non-existent), perhaps in part given its longer historical experience of such policies.

the pinnacle of achievement and security for many families. Many young people marched against the prospect of the introduction of reservations in centrally-funded higher education institutions, which had also been recommended by the Mandal Commission. For upper caste children and their families, possession of the capital necessary for admission to elite institutions did not necessarily translate into an assumption of easy access – a vision of their chances becoming even slimmer was a frightening one. Delhi University student Rajiv Goswami became a symbol of this potent milieu following his self-immolation attempt in Delhi (Venkatesan 2010: 144).¹³¹

The 1990 protests subsided once the Supreme Court heard a petition against the proposed policy.¹³² In 1992, the Court upheld the validity of the OBC quota contingent on the exclusion of the ‘creamy layer’, and the policy was enacted in 1993. The reaction was muted, suggesting resignation by protestors to the reality of reservations. But perhaps more crucially, the quiet reception of the new system reflected the changing socio-economic landscape. By 1993, private sector careers in the newly liberalized economy were proving more attractive to the scions of privilege than the careers in government service coveted by their parents and grandparents. By 2006, following the most transformative decade of independent India’s socio-economic history, the primacy of the private sector over the public in the career aspirations of the country’s young elites had taken on the mantle of conventional wisdom (Corbridge et al. 2013: 295), making the question of public sector job reservations less threatening. But the introduction of reserved seats for OBCs in centrally-funded institutes of higher education remained inflammatory.

While the dominant narrative of those who oppose reservations on grounds of ‘inefficiency’ (see below) recognises the poor quality of schooling experienced by many lower caste students, the idea of innate capacity has not entirely

¹³¹ Goswami died in 2004 following years of health problems. During the 2006 agitation, student protestors referred to the AIIMS intersection as *Rajiv Chowk* (Venkatesan 2010: 144).

¹³² The petition challenged the policy on three grounds. Firstly, that the OBC quota violated the Constitutional guarantee of equality of opportunity. Secondly, that caste was not a reliable indicator of backwardness. Thirdly, that the proposed quota threatened the efficiency of public services (Venkatesan 2010: 145).

disappeared. Radhika Chopra (2005) has studied teachers' attitudes towards lower caste children in primary school classrooms, noting an improvement in recent years alongside a persistent belief by some in the inherent 'educability' of pupils depending on their caste. The more pernicious objections to the introduction of reserved seats for lower castes have always been imbued with the residue of nineteenth-century eugenicist thought which naturalized intellectual ability, or lack of, as a feature of racial type; where they still exist in the contemporary narrative, these prejudices hide within a discourse of merit (Subramanian 2015).

A petition to the Madras High Court in 1950, challenging state-legislated reservations in education, claimed that: 'It would be strange if, in this land of equality and liberty, a class of citizens should be constrained to wear the badge of inferiority because, forsooth, they have a greater aptitude for certain types of education than other classes (para 54)' (Madras High Court, cited in Deshpande 2013: 37). In his 1983 report on the institution, the director of IIT Madras reflected on the legislation that protected seats for SC/ST students by establishing a dichotomy between 'the socially-deprived' and 'the talented', 'special privileges' and 'rights', and 'Indian' versus 'international' standards. The same individual took the Government of India to court in 2011 in an effort to dismantle the 2006 reservations for OBCs (Subramanian 2015: 312). In his account of the 2006 anti-quota agitation by doctors and medical students, Venkatesan notes the following wording of one of the writ petitions filed in the Supreme Court: 'The statute has lost sight of the social catastrophe it is likely to unleash. The products [of the educational institutions, if the OBCs had reservations] would be intellectual pygmies as compared to normal intellectually sound students presently passing out' (2010: 148).¹³³

During the 2006 agitation, while YFE declared its allegiance to an equitable, casteless society, particular methods of protest were rich with caste

¹³³ The eponymous petitioner in the main case, Ashoka Kumar Thakur Vs. Union of India and Others, was an advocate in the Supreme Court. Venkatesan argues that by ignoring standard protocol that would demand the writ be re-phrased without the use of offensive language, and by including the original phrasing in the 2007 Interim Order that imposed a stay on the implementation of the Act, the judiciary betrayed caste prejudice and an alliance with the striking members of the medical community (2010.: 150–151).

symbolism. By sweeping roads and shining shoes at traffic lights, upper caste students enacted a vision of the demeaning future that awaited them should institutions be made more accessible by members of caste groups traditionally responsible for such services (Hasan 2009: 102–104).

While the 2006 agitation was smaller and more circumscribed than the 1990 protests, it forms an important chapter in the history, and therefore the contemporary life, of AIIMS. In 2007, a government-appointed committee headed by Professor Sukhadeo Thorat submitted a report into caste discrimination at the Institute (Government of India 2007). In the section about the 2006 agitation, it states that the protest at AIIMS took place with the encouragement and facilitation of senior faculty, including the director at the time, Dr P Venugopal:

The involvement of the administration in supporting the agitation was alleged on the grounds that the same administration had strictly applied a court order banning agitations within 500 metres of the AIIMS on previous occasions when workers went on strike. But this time, the striking students and resident doctors had parked themselves in the central lawns. A tent was installed at the site to protect the striking doctors and students. The striking-persons also stayed at this site during the night. At any time, 50 to 100 persons were on hunger-strike at this venue. The erection of shamiana, provision of electricity for coolers and other comforts such as mattresses and pillows, they allege would not be possible without the support of the administration. (Gol 2007: 60)

Those faculty members and students who supported the reservation policy reported harassment by their peers and complained about the behaviour of the medical superintendent who demanded that faculty ‘report for hunger strike’ (ibid.). Dr R Deka, then a dean of the Institute who would go on to be director from 2009–2013, testified to the committee that he had been harassed and humiliated by the leaders of the agitation, to which he was opposed.¹³⁴ Dr Deka alleged that such events could not have proceeded without the sanction of the

¹³⁴ *Placebo* (2015, dir. Kumar) shows students protesting outside the director’s bungalow during Deka’s tenure, in the wake of the suicide of an MBBS student in the ST reserved category (see below).

director and that some of those involved in the harassment were residents working under Dr Venugopal (ibid. 61–62). SC/ST students told the committee that they had been pressurized by the dean of examinations, Dr TD Dogra (who became interim director from July 2007–March 2008), into withdrawing complaints of harassment or discrimination, and spoke of wanting to attend classes during the strike but being ignored by faculty.

The Thorat Report was rejected in its entirety by the AIIMS administration. An eight-member review committee concluded that ‘the Thorat Committee acted with a clear prejudice to deliver a misleading report that relies on imaginary facts, flawed methodology and baseless conclusions apparently with the sole purpose of discrediting the AIIMS’ (Dhar 2007).

Vincanne Adams (1998) has written about the role of health professionals in the 1990 democratic revolution in Nepal. Doctors at Tribhuvan hospital in Kathmandu chose to strike in response to the state’s violent reaction to pro-democracy rallies. This politicization of members of the medical profession occurred as leaders of the movement saw an opportunity for a biomedical epistemology to contribute to the shaping of a nascent democratic process. In India in 2006, by contrast, a medical strike took place as a means of demonstrating a profound dissatisfaction with events occurring under the auspices of a democracy that was approaching 60 years old. Venkatesan suggests that although the YFE protest ostensibly espoused democratic, egalitarian ideals, the movement betrayed contempt for parliament and the political system (2010: 146, 148–149). This distrust cannot be divorced from the evolving political and socio-economic scenario in which these students had come of age. The discourse of privatization, economic growth, geopolitics, and disillusionment with the state permeated the 2006 protests. In the transformation of caste capital, Deshpande argues, caste itself becomes elusive: ‘it appears to be a story about something *other than caste*, like the story of nation-building for example, or the story of a great and ancient tradition modernising itself’ (2013a.: 33). Against this new socio-economic backdrop, then, YFE could claim that reservations were not only a violation of equality motivated by ‘vote bank politics’, but that by

undermining ‘efficiency’ they also posed a threat to India’s national development and its burgeoning status as a global ‘superpower’ (Jodhka & Newman 2007).¹³⁵

‘Caste doesn’t matter here’

Me: Is there any caste discrimination at AIIMS?

Mihir: No, no. If I have to say as a blanket statement, I’d say that in AIIMS there is no, yeah it’s totally non-existent, any segregation, or any politics on basis of caste. Me personally, I wasn’t aware of any of my colleagues’ status for the first year. I only got to know that in the second year when there are SC Student Union elections going on. So at that time yes, these things may come up, sometimes. But those are only closeted discussions, not in the public. So yeah, I won’t say it is existent any more.

...

Me: Are you aware of other students’ castes?

Priya: Yeah, we did know because there is a list of all the selected people, so you get to know. It’s written in front of the name, that this is general category, this is this, like category-wise there are names written. So we get to know. But in AIIMS I didn’t personally get any such different treatment as such, because I myself am a reserved...but I have heard, in other colleges, especially in Rajasthan and Madhya Pradesh there is a lot of such discrimination going on, because the general people have this problem that the people get reservation, so they don’t find it fair enough, so they have their own community. In AIIMS, it’s not at all like this, not at all in AIIMS. But then, yeah, in other colleges, in periphery of India, I have seen, there has been a lot of discrimination, there are fights going. There are these groups you know, gangs, general people and ST people like that.

I begin this section by juxtaposing the comments by Mihir (general category) and Priya (ST) in order to demonstrate two things. Firstly, the commonplace denial among general category students of any awareness of caste identity or reservation-based differentiation among their peers – an attitude which extends in some cases to obfuscate the accumulated capital advantages of upper caste students behind a veneer of merit (Subramanian 2015). And secondly, the way in which this purported ‘casteless’ worldview is denied those whose access to and

¹³⁵ See point 10 on the YFE agenda: ‘Promote excellence: build India [into] a superpower’: <http://www.youthforequality.com/our-agenda/default.aspx> [accessed 13 December 2015].

presence at AIIMS is contingent upon their adherence to a particular reserved category. These related points have obvious implications for who experiences AIIMS as a social island – or an interstructural liminal space – and how. It is with this in mind that I proceed through the following pages.

Priya was unusually candid in acknowledging that students could learn the category affiliations of their peers through the official admissions sheet.¹³⁶ More common was an assertion of initial ignorance followed by a gradual realization of who was who, revealed either through a concrete method such as Student Union elections for SC/ST representatives, as in Mihir's case, or assumed through behavioural observations, as in Anjali's example, to which I return below. Priya was not alone, however, among students in reserved categories in denying any experience of overt discrimination among peers at AIIMS. 'We talk amongst friends and we all feel that there is no discrimination on the basis of caste,' Dhananjay said.¹³⁷ This narrative is very different to that of the 2007 Thorat Report, which reported systemic discrimination against lower caste students and faculty. Several students I spoke with acknowledged this history and said that times had changed:

Not now, a few years back it was bad. Not now. At that time there was very much a big struggle in AIIMS, like politicians came, everyone came, it was a big issue. It was like a kind of fight. But now it's a wonderful environment, everybody is so friendly and eats in the same plate. – Nikhil

Deepak offered a less glowing assessment than Nikhil and suggested that discrimination persisted to some extent, but that things had improved significantly since the days when the student hostels reflected a de facto system

¹³⁶ In June, AIIMS releases the MBBS entrance exam results – the list is disseminated through the media, and includes full names, ranks, and reserved category affiliation (a blank space implies general category, emphasizing the erasure of denoted caste for those from advantaged groups).

¹³⁷ While friendship groups were not strictly delineated along lines of category affiliation, such conversations, it seemed, largely were – see Mihir's comments below for another example. In Dandekar's study of medical students at GMCM Maharashtra, respondents from the general category reported that 78% of their friends were from the general category and 22% from reserved groups, while those from reserved groups reported 48% of friendships with other students with a reservation and 52% with people in the general category (2013: 124).

of segregation enforced through the systematic bullying of SC/ST students in particular¹³⁸ (GoI 2007: 32–36). I did not live on campus at AIIMS, nor did I spend sustained periods of time in the student hostels and so I cannot be certain that students were not intentionally protecting the image of AIIMS in their discussions with me. The willingness of many of them to critique the institution along various lines, however, including in terms of caste discrimination among faculty, suggests that their reflections were honest, and that while discrimination has by no means been eradicated, caste relations among students are nowhere near as inflammatory as they were a decade ago.¹³⁹ What I would argue remains most salient for my ongoing exploration of how AIIMS is both insulated from and permeated by social norms, is the tension between the statement by Santosh (OBC) that ‘caste doesn’t matter here,’ and the multiple instances when it appears that, in fact, it does.

In keeping with the thesis as a whole, this chapter is primarily focused on students at AIIMS. However, it is essential to note that it is faculty members in reserved categories who are generally understood to experience the most enduring, systemic discrimination at the Institute. ‘There is a deep rooted hatred’ at AIIMS for lower castes, long-serving faculty member Dr N told me. The Thorat Report condemned systemic discrimination against reserved faculty at AIIMS, which included denial of promotion, research opportunities, student supervision, and international conference participation in favour of colleagues, sometimes junior, in general category positions (GoI 2007: 53–58). It is the outright denial of employment to SC/ST and OBC candidates, however, that continues to attract the most attention (The Hindu 2010; The Statesman 2015). When I raised this issue with a senior member of the administration, he

¹³⁸ The most explicit bullying, including locking students in their rooms and writing abusive messages on their doors until they agreed to move to a different floor of the hostel, took place in the men’s hostels. Fewer female students reported direct bullying, but those in reserved categories tended to form their own social clusters.

¹³⁹ In this, I follow Claire Wendland’s reflection on the shortcomings of relying predominantly on interview material for her analysis of certain themes among students at the medical college she studied in Malawi: ‘...I have to assume both that students were the best source of evidence about their own process of becoming doctors and that some evidence was missing or misleading’ (2010: 235).

acknowledged that caste discrimination in recruitment used to be a problem – quotas were ‘misused’ and it was often claimed that there were no suitable candidates from reserved categories in order to allocate posts to unreserved applicants on an ad hoc basis. This was ‘no longer possible’ he claimed, given the fixed and ‘very transparent’ nature of the present recruitment mechanism.

A letter I was shown by a member of the Forum for Rights and Equality at AIIMS (FRE 2015), which exists to expose caste discrimination at the Institute, suggests otherwise. The six-page note, written in January 2015 to then Secretary of Health Lov Verma, is a response to a meeting held at the Ministry of Health and Family Welfare in December 2014 to discuss a petition submitted to the health minister (and president of AIIMS) ‘highlighting the different instances of denial of reservation’ at AIIMS. According to the letter, the petition demonstrated how the AIIMS reservation roster was manipulated ‘to undermine the representation of SC/ST/OBCs in faculty’, and noted that despite assurances there had been no explicit intervention by the health secretary to interrupt the process of selecting faculty on the basis of the disputed roster. The roster makes fewer reserved faculty posts available than the law demands, and the Institute’s unilateral decision to fill places with unreserved candidates is unconstitutional, according to the Forum. Following a court case about the same issue in 2003 (following the 2003 recruitment round, of 13 posts reserved for SC/ST and 46 for OBC, all but 8 in total were filled by general category faculty), when the Government of India declared that all ad hoc appointments of upper castes to reserved category faculty posts should be quashed, AIIMS filed an affidavit claiming an administrative mistake. The case is currently pending with the Supreme Court.

*

During Pulse in 2014, I spoke to two brothers from Bihar. The younger brother was studying for an MBBS at the B.P. Koirala Institute of Health Sciences in Nepal (established with support from AIIMS in the mid-1990s) and was visiting his elder sibling who had graduated from the same college and was now a

junior resident in anatomy at AIIMS. They had both been inspired to pursue medicine by their father, a surgeon, in whose footsteps they hoped to follow. They were joined by a friend who had attended the same private boarding school in the Uttarakhand hills, whose alumni include notable names in the Indian Foreign Service, academia, and entertainment. 'We are from a school in which we never knew what was caste,' the friend said. The brothers agreed, and the younger sibling responded to my question about how the problem of insufficient postgraduate seats in medical colleges should be resolved:

Reservation for upper caste poor...they are very poor and they don't have any reservation. In my entrance exam for MBBS, I had got double the marks of a guy who was Scheduled Caste, and that guy got through and I couldn't get through. So even if you are not believing in the caste system, when I studied in school your system is like you should not believe it, when you go through that you start believing. Because it all becomes about caste, when you give an entrance exam.

For this student, the biographical number of rank is imbued with a grievance that his meritorious achievement was subordinated to a political intervention based on an unjustified and outmoded argument of caste advantage. His statement is a precise illustration of Ajantha Subramanian's description of a 'back and forth movement between the marking and unmarking of caste' by members of the general category (2015: 293). Drawing on Marc Galanter's work on India's 'competing equalities' (1984), Deshpande argues that this current order of things can be understood through a Constitutional commitment 'to pursue the conflicting policies of social justice and caste-blindness':

As a consequence, the privileged upper castes are enabled to think of themselves as 'casteless', while the disprivileged lower castes are forced to intensify their caste identities. This asymmetrical division has truncated the effective meaning of caste to lower caste, thus leaving the upper castes free to monopolise the 'general category' by posing as casteless citizens. (2013a: 32)

In her work on the discourse of merit at IIT Madras, Subramanian agrees with Deshpande's assertion that 'castelessness holds the key to caste' (2013a: 33), but

she is concerned to reveal how an expression of casteless identity might in fact disguise the reinscribing of upper caste identity ‘as an explicit basis for merit’ (Subramanian 2015: 293). In this discourse, given the general category ownership of ‘open competition’, only those students admitted without reservation (those, in the case of AIIMS, ranked 1-37) can be truly meritorious. A member of the OBC or SC/ST quota admitted to AIIMS will have a higher overall rank than many thousands of general category candidates who missed the cut-off, but their perceived advantage precludes any meritorious status¹⁴⁰. The visibility of the role of caste and the state in enabling their admission is at odds with the invisibility of those agencies in accruing the capital that propels admission via the general category, allowing for a discourse of innate talent, and ensuring that the rhetorical weapons of merit and equality remain firmly in the hands of society’s most traditionally privileged groups (Subramanian 2015: 293).

Part of this obfuscation work is done by the very terminology of a ‘general category’, which, by definition but not by explicit description, is dominated by upper castes. Deshpande (2013a) argues that the ‘general category’, born in conjunction with the OBC reserved category, supports a narrative of castelessness espoused by upper castes in relation to the ‘hypervisibility’ of lower castes. Acknowledging membership of the general category may be an implicit indicator of a likely caste bracket, but it does not elicit the specific identity made clear in the articulation of membership of either the OBC or SC/ST reserved categories. On the exam results table, students either have ST, SC, OBC, or a blank space next to their name, the latter suggesting not a membership of a category but a default belonging to the norm, from which reserved groups are set apart. As Deshpande puts it, the ‘general category is the preferred antonym for “reserved category” in everyday language, even though it is arguably the latter which serves the widest cause, while the former is more of a sectional or

¹⁴⁰ This becomes more complicated, however, when a candidate in a reserved category achieves a high overall rank, as in 2016, when an OBC student was ranked second. In this case, while the OBC appellation may still deny the student entrance to the meritorious category, his choice to apply for a reserved seat leaves open a seat in the general category that he would have otherwise occupied, given his superior rank.

particularistic interest' (2013b: 25). Reservations and their categories, then, reify caste for everyone to some extent, but only those at the lower end of the spectrum are forced to give it voice.

Both Deshpande (2013a, 2013b) and Subramanian (2015) are careful not to impute false consciousness to young people who profess a casteless identity. They agree that the allegiance of many upper caste people to 'modern' citizenship and universal ideals is sincere. The thoughts of the student from the college in Nepal above afford an insight into this subjectivity by suggesting a narrative of modernity liberated from considerations of caste, only to be compromised by the regressive politics of reservation. In being taught 'not to believe' in caste, the pupils of the elite school in the hills are crafted into cosmopolitan citizens who espouse universal ideals of democracy, equality, and rationality – within which is embedded a particular interpretation of merit detached from caste histories. The MBBS student presents his encounter with caste – presumed to be the antithesis of the values he has been taught – as a rather distasteful experience, as though he finds himself mired in a pre-modern swamp that he is forced to wade his way through.

Further, his suggestion of reservations for poor members of upper castes not only speaks to the enduring critique of caste rather than class as the basis for calculating deprivation (and to a flexible conception of poverty), but also demonstrates the way in which reservations have become a naturalized dimension of Indian social and political life. In stressing his superior rank to that of the SC student who was admitted (to AIIMS, we might guess given the context, but he didn't specify) while he wasn't, he gives familiar expression to the discourse in which merit is ill-advisedly subordinated to political accommodation. He seems to be an exemplar of the phenomenon that Deshpande describes as follows:

Long accustomed to a comfortably homogeneous environment populated almost entirely by people like themselves, this group is unsettled by the recent arrival of hitherto excluded and therefore strange and unknown social groups in their vicinity. It is the double

coincidence of the maturation of a sense of castelessness and the arrival of caste-marked strangers in hitherto upper caste social milieux that confirms and amplifies this response. (2013: 38)

For a student to deny caste as a defining aspect of her identity is not necessarily to deny the instrumental role of inherited privilege in her life, however. In the previous chapter, we heard Anjali's acknowledgement of the ways in which her path to AIIMS was sufficiently smoothed to make admission feel almost like a foregone conclusion. Anjali's generation, Deshpande notes, is 'distanced from the process of the conversion of traditional caste capital into secular modern caste-less capital that previous generations effected' and as such, in their life experience, the family unit has had a much more explicit role in bestowing social capital than has caste (2013a: 38; Beteille 1991). This reality is apparent in contemporary understandings of *class* as having a more direct relationship with privilege than caste (Corbridge et al. 2013: 257; Fernandes 2006). Nor is this narrative necessarily confined to upper castes disgruntled with what they consider a flawed reservation system. Priya joined AIIMS through the ST category and expressed discomfort about her eligibility:

Me: Why don't you support reservation?

Priya: I don't, because then people think this seat is given out of pity or something. Me getting one is not my fault! And I guess I can anyway fight for it. Me being a backward caste, but still my dad is earning the same as a general family, so financially we are good enough, so I guess that ways the people would be, like my friends in the general category would be thinking that she's getting all the same facilities then why is she getting reservation. I guess it might be true on their side, but people who genuinely need it, because there are still people who don't get facilities and they really try hard to get into AIIMS or PMT...they also don't get much exposure, they don't have facilities. General people study in good schools, have good personality development, unlike SC/ST people and other OBCs, so that ways it's good. But then I guess fair distribution should be there also, like I don't think I needed one. The creamy layer should be I guess removed...but the deserving should get it.¹⁴¹

¹⁴¹ Currently, only the OBC creamy layer is excluded from the quota by court order. However, the fact that Priya appears to consider herself part of the ST creamy layer shows how unstable these categories are, and that it is not only upper caste voices arguing for affirmative action to be adjudged on economic rather than caste criteria. Questions about the creamy layer within SC/ST groups may soon be on the political agenda (Deshpande 2013b: 37).

Priya's ambiguous feelings about accessing AIIMS through a reserved category illustrate Long and Moore's argument for understanding achievement as 'at once intensely personal, relational and intersubjective,' with implications for 'one's own life and the matrix of relations one inhabits' that might include a feeling of guilt or ambivalence as well as joy in the wake of achieving something long sought-after (2013: 14).

While Anjali wasn't entirely opposed to reservations when the policy was enacted, she had become 'concerned by the consequences.' 'Efficiency suffers' she said, when less capable people are promoted purely in keeping with reservations. 'People should be enabled,' and given more support during their schooling, she suggested, but reservations should cease at the graduate level.

Akin to the narrative that posits a concern over merit as a concern for national development, a discourse of efficiency is the default defence against reservations within the private sector in particular, as Jodhka and Newman (2007) demonstrate in their survey of attitudes among companies in Delhi (also see Shah 1991 for an earlier example of this argument). Subramanian (2015) draws on Carson (2006) to note that objections to reservations articulated through a discourse of efficiency contain echoes of the modern history of Western political thought, wherein efforts to create more equitable societies were underpinned by an understanding that hierarchies would persist on the basis of people's different innate capabilities.¹⁴² Legitimizing natural intellectual variation allowed for the establishment of societies that could appeal to nature and rationality while promoting 'virtues and talents'. Challenging this stubborn perception in India, Parry (1999) shows the lack of evidence for a detrimental impact of reservations at the Bhilai Steel Plant in Chhattisgarh, while Deshpande and Weisskopf (2011) have demonstrated that a higher proportion of SC/ST employees in the Indian Railways has not had a detrimental impact on

¹⁴² Nor has this discourse disappeared in the West. As I wrote this chapter, the late US Supreme Court Justice Antonin Scalia suggested during the hearing of a case about an affirmative action admissions policy at the University of Texas that black students might be better off attending 'a slower-track school where they do well' rather than a highly selective college that has taken race into account when admitting them (New York Times 2015).

productivity. If anything, the opposite has proved true, and the authors mount a tentative argument that greater diversity in the labour force boosts productivity.

I encountered one representation of the private medical sector as happily unencumbered by reservations and their detrimental consequences during an interview with two directors at Max Healthcare. The section of the interview I reproduce here began with a reflection by one director (D₁) on the decline in standards he had observed at his alma mater since the introduction of reservations. He went on to say that AIIMS was likely to be the top choice for aspiring medical students for the foreseeable future, and that this 'quality of human resources' was what enabled the institution to maintain high standards despite the pressure of an enormous patient load.

D₁: So by default they would anyway get the best people. And when the starting material is good, exiting material has to be good. So it's a selection bias, which hasn't been really purposely created, but over the years when competition has gotten to that level, that the best of the lot...would get selected at AIIMS. And once you are doing your graduation there, by default you are preferred for postgraduation. And by default, if you have [studied there for] 10 years, you are given preference for faculty. So you keep going up the stream, up and up. You come as a best student and you remain there as the best student until you leave. What is causing this change of mix is a very controversial issue, which I don't want to really discuss too much, is the reservation. Which is the main reason why institutes like these are getting diluted. AIIMS also will ultimately fall prey. Other institutes have already...like the ones I'm talking about – Maulana Azad and all. This is something which is sad.

D₂: So like he said, as long as the best and the brightest go there, there is no problem. But you start fiddling with that fundamental...

D₁: By doing reservation you are changing that mix.

D₂: You are changing that mix. Then you have a problem. And it's going to perpetuate over a period of time. It's not a political statement by either of us; it's a statement of fact. That's the way it is.

D₁: And the effect of that policy change you see only after about a decade or two decades. That's the stage where most of the hospitals presently are, the public hospitals.

Me: And the private sector is wholly exempt from the policy?

D1: Yes, luckily. So far. The government keeps changing, but keeps talking about pressurizing or doing something about it. So far no one has...they have been talking about encouraging private organizations also to hire people like that. But there has been no law as yet.

While the medical context was obvious in this conversation, there was no explicit articulation of the impact of reservations on medical practice specifically. It was Mihir, back at AIIMS, who raised this point.

Me: If you were a policymaker, and you could make one intervention in health policy, what would you do?

Mihir: Yaar, I don't know. What we generally discuss is that because right now we are students and we are more in sync with what they are at, say at the academic level, so what we would like is actually maybe the amount of reservation there is...maybe I'd decrease it. I don't know, I mean this is a very controversial point. Generally what we have seen is that at least for a profession in which you are handling people's lives, you shouldn't allow someone with less merit to be before someone with better merit. So that is one thing which we discuss a lot of times.

Me: You discuss this with your friends?

Mihir: Yeah, yeah. This is a sort of thing which we can't discuss in public right now, because this is a very sensitive issue, people take offense very easily. And the other thing is that it's not like everyone in the reserved category is incompetent, but the percentage who are incompetent, if you compare general and the reserved, it's definitely high. At least in my eyes. So that is one thing we would like to be not there.

Me: Is that your own observation? Have you observed that at AIIMS?

Mihir: At AIIMS too, yeah. And sometimes it's from other people's experiences also which they have told me. So yeah that's one thing, definitely.

In his account, Mihir invokes a moral dimension of reservations, linked to a doctor's responsibility for life and death. This recalls Deshpande's observation above of moments in which caste is effaced by an intention to construct an alternative narrative, such as that of nation-building, or development, as seen in the YFE case (Venkatesan 2010), or among IIT students and alumni (Subramanian 2015). This discourse implicitly privileges upper castes as rightful 'owners of the nation' (Deshpande 2013b: 41), in whose hands should rest the

responsibility for enacting and distributing development. Sarah Pinto (2004) beautifully articulates the ‘deceits’ that are revealed when the ‘wrong people carry off mimesis’ in the development project:

The first of these deceits is the idea that universal knowledge (of medicine and development) precedes power and legitimacy, and that power (economic, political, self-mastery) and authority in a modernizing world come from correct understanding instead of being mutually constitutive...The second set of deceits concerns the bundling of education and equality. This includes the notions that medicine and development embrace a politics that is separate from the interests of particular groups or individuals, as is asserted in global health policy (Adams 1998); that the legitimacy of development is available to all who enter into certain universalized ways of knowing by participation in authorizing structures; and that universal knowledge manifests itself in the same way and is equally available to all who seek it out. (Pinto 2004: 358; also see Pigg 1997; Pinto 2008)

In Mihir’s reasoning, the sanctity of medicine itself is privileged. Here, it is not solely a broad vision of national development that is imperilled by reservations understood as ‘concessions to narrow particularistic interests’ (Deshpande 2013b: 15) ill-suited to the task, but the actual lives of its citizens. This sets up a dissonance in which the traditional nobility of medicine cannot in good conscience partake in this particular effort to improve social justice:

The need for merit discrimination in particular may be ideologically exaggerated by the claim that higher education (or at least part of it) is engaged in knowledge production and must therefore cultivate ‘excellence’ to the exclusion of all other objectives (such as those of equity), or even that it must be exempted from such social responsibilities. (Deshpande 2013b: 15)

It is this purported ethic of concern for human life with which meritocratic discourse is imbued that appears to differentiate the discussion of reservations in medicine from other fields.

'You have to fight your fight'

'Discrimination' is a freighted term; when associated with caste in an environment with relevant history, like AIIMS, it has dramatic and often violent connotations.¹⁴³ While Priya, Dhananjay, and Purush denied personally experiences of discrimination, they each alluded to the stigma attached to reserved seats.

Priya: But then I know, there were friends of mine who were kind of jealous because, in my coaching times I had my competitors, like friends and all, and we used to get good ranks, like top ten or something. So they knew that we are good, same level as each other, then later on I got selected in AIIMS, and they got a random college...of course I got some benefit, definitely. So they would not have liked it, I know that. They might have you know, talked behind...so it's like that, people might be jealous or something, but they won't tell that on my face. That's what I am saying. In Delhi, the scene is less bad, as compared to other areas, where there is a lot of discrimination going on.

When I returned to AIIMS briefly in March 2016, Dhananjay and Purush were studying for the postgraduate entrance exams. Recall Anjali's description of students in reserved categories: 'they are the ones who are always relaxed...[they] don't have to bother because they know they've already got a PG place.' Dhananjay and Purush were well aware of this perception. How did it make them feel, I asked. Purush grinned and gestured at Dhananjay. 'It makes him angry,' he said. Dhananjay shook his head and smiled. 'Not angry,' but at the back of his mind he felt like he should work harder, 'even though I'm working as hard as they are.' A general category friend had recently told him that he would get a PG place more easily. 'I understand their position,' Dhananjay said. 'I take it as motivation.'

This tussle between shrugging off and rising to implicit accusation was evident in Purush, too. After teasing Dhananjay about being sensitive, and

¹⁴³ See Donthi (2016) for an investigation into the circumstances that led to the suicide of Rohith Vemula, a Dalit PhD student at the University of Hyderabad, in January 2016 – a case that dominated the headlines and provoked a periodic bout of national outrage before fading from view. Also see Sukumar (2013) for a first person reflection on life as a Dalit student at the same university. And for recent work on the anthropology of affirmative action in South Asia more broadly, see the special issue of *Focaal*, edited by Shah and Shneiderman (2013).

telling me that the assumption that reserved seats came easily was 'not hostile', Purush added that he was not aiming for the lower marks required for an SC/ST seat. 'I am not studying for five hours, while general people study for ten,' he said. Towards the end of our conversation he mentioned that he had conducted an informal study and found that Facebook status updates confirming PG admission got more 'likes' if they were posted by general category students than by SC/STs.

Priya commented above that 'general people study in good schools, have good personality development, unlike SC/ST people and other OBCs.' This notion of 'good personality development' alludes to the ways in which disadvantage can be coded through habitus (Bourdieu 1984), and becomes another way of discussing merit from within the unmarked general category. Usha Zacharias remarks on the imagery used in the India Today institutional rankings report: 'The majority of the images presented fair-skinned, upper middle class, Westernised students radiating confidence, positive energy, and a general sense of "fitness" to confront the world of opportunities' (2013: 291–92). This sense of 'fitness' speaks both to Priya's description of personality development, and also to the efforts Dhananjay made during his time at AIIMS to 'change [his] personality for the better.'

As Zacharias (2013) notes in her reflections on a programme designed to enhance the 'soft skills' of lower caste students, while the habitus of difference is also expressed through clothing and eating habits, it is language and communication that have the most expansive impact on how an individual experiences an institution and on how they are perceived. Bourdieu describes linguistic competence as 'a dimension of bodily hexis in which one's whole relation to the social world, and one's whole socially informed relation to the world, are expressed' (1991: 86). At AIIMS, the language that matters most is English.

English...is a whole set of intervening cultural apparatuses, knowledges and filters that separate out circles of peer networking and social circles in college. Far more than a language, English on campus represents a set of cultural competencies and idioms of interaction that finely

differentiate students based on the kind of schooling one had: not just between private and public, but of hierarchies within the private and within the public (Zacharias 2013: 300; see also Fernandes 2006: 68–69).¹⁴⁴

Nor are these hierarchies necessarily confined within the student body. When I asked Anjali if she thought that reservations were an effective mechanism, she shook her head immediately. She had slept through a class that afternoon, she said, because she couldn't understand the lecturer: 'He couldn't talk sense.' On a previous occasion she had told me that, 'when you come here half the professors are speaking in an accent of English you can't really understand. And you are like, OK, I am going to waste the next hour just sitting here, and not really understanding anything.' In this case, the traditional authority in the faculty-student relationship is undermined and allegiances are redrawn under the guise of a defence of merit.

The Thorat Report condemned the failure of the AIIMS administration to provide support to SC/ST students who arrived without the breadth of academic training required to excel during the MBBS.¹⁴⁵ Poor English skills were cited as a particular concern. Dhananjay spoke in the previous chapter about the necessity of English-medium schooling to AIIMS admission. He had attended an English-medium school himself, but spoke no English at home (recall his anecdote about his admission letter being translated from English to Hindi), and told me that he improved his language skills at AIIMS through YouTube.

In 2012, a batchmate of Dhananjay and Purush hanged himself from the ceiling fan in his hostel room. The son of a farming family in Rajasthan, he had reached AIIMS through the ST reserved category (and came second in the ST

¹⁴⁴ The complex institutional politics of language were thrown into relief during my observation of the opening ceremony of Pulse 2014, when the director of AIIMS addressed students visiting from all over India in *shudh*, or pure, Hindi. This occurred a few months after the election of a BJP majority government, which made the elevation of Hindi in the bureaucracy a priority (see chapter 6).

¹⁴⁵ In her study of GMCM Maharashtra, Dandekar (2013) found that 80% of SC/ST students reported having difficulties with English as the medium of instruction, versus (a not insignificant) 15% from the general category. Only 8% of SC/ST students reported facing no difficulties with any aspect of the MBBS course, versus 44% of general category students (122).

group of the AIPMT) following a Hindi-medium school education. While he had enrolled in private English lessons, his friends and family blamed a lack of institutional support for his poor exam results that they maintained led to his suicide (Jha 2012). The film *Placebo* (2015) documents the aftermath of this suicide, including angry student protests outside the silent director's bungalow. But while purporting to expose the darkness of the institution, the film enhances it, fuelling the myth of a homogenous student body by making no mention of caste or reservations. With regard to an earlier suicide, a student explains how strange it feels that he didn't know the individual in question. 'He was just some Hindi guy,' he says.

I asked if Dhananjay had ever been offered support from faculty for improving his English. He shook his head. 'No. You have to fight your fight.' *And then he laughs, my notes say, but there is a weariness in there, not entirely hidden.*

'Pull him up, pull him up, pull him up'

While reservations enable access for some to a previously inaccessible domain, they ensure neither full inclusion nor 'equalisation of access to the resources that determine success in higher education' (Deshpande 2013: 4). In August 2015, a female MBBS student hanged herself in her hostel room. She was the fourth student from a reserved category to commit suicide at AIIMS since 2010 (Pandhi 2015). In 2012, AIIMS responded to the growing concern about caste discrimination at AIIMS first articulated in the Thorat Report by establishing a two-week orientation programme for incoming students run by the Centre for and Education for Social Transformation (CREST) based in Kerala (see Nampoothiri 2013 for an overview of the organization's work). Given the timing, the main student protagonists of my thesis had no such orientation and weren't very familiar with the CREST programme other than vaguely approving of its intentions. The programme connects each student to a faculty member with the ostensible aim of supporting students from disadvantaged backgrounds. While I didn't have the opportunity to attend any of the CREST sessions, a recent article

in the periodical *The Caravan* cites student scepticism of its impact, particularly on caste relations (Pandhi 2015). Rahul told me that in his observation it was common for new students to register at AIIMS and then return home for the CREST fortnight before the semester began.

Dr T, a senior faculty member, said that the nature of the additional support afforded to students was entirely dependent on individual teachers. Dr T was motivated both by a concern for the AIIMS brand, and her own reputation: 'I would like them to know without telling my name; everybody should know that this student has studied under me. It should be that good. Nobody need to ask, "Who trained you?"'

When I asked whether she perceived any particular threat to the AIIMS brand, our interview continued as reproduced below. Dr T began hesitantly, and when I realised she intended to talk about reservations, I reassured her of anonymity in anything I might write about our meeting; we laughed, a common and uncomfortable deployment of humour in an effort to create a secure space in which to express opinions deemed sensitive.

Dr T: Because like, you know, I have student who has entered with rank 12, and I also have student who has entered with rank 83, so when we don't have the equal type of calibre of students then no matter how much we try to take this fellow from 83 level to level of twelve...

Me: So you notice that difference, between ranks 83 and 12..?

Dr T: Too much difference. Earlier too much difference was not there. Now too much difference is there because of the quota system, in the entry. So someone entering from general category has a higher rank, somebody is entering from another quota category is a lower rank. So when we keep these two together it is very difficult to bring this student up to that level. So sometimes they become impatient. They become impatient. And the person who is with higher rank, we are giving less attention to that person. And we are giving too much attention to this person who came in with lower rank to pull him up, pull him up, pull him up. All our energy is going in that. Earlier I had students all with 12, 13, 14, 15, 16 rank. So I could just give instructions – ten minutes – they will bring the output, and then ten minutes next instructions, excellent output. So I could just claim that all the students, under my hand, are best in the country, but now in order to maintain that feeling I have to keep on pulling the one who came from lower level, and neglecting the one who is from upper level because there are only 24

hours in a day. And how much work you can do in a day? So I feel the superior students are getting neglected. I have this view.

Me: Is there a facility for lower ranked students to have extra tutoring?

Dr T: Every teacher has to put extra hours. Like I do that so many times – put extra hours – but sometimes I feel students are feeling harassed, tired, and frustrated that I am giving... They may realise that I was after them for a particular purpose, but that is after leaving they may realise. But when the process is going on that time it may hurt them. Today morning only, that student with 83 rank, morning I expected that she will do something. Yesterday I sent two, three mails to her. I sat in my home at night and did more than 30 reviews of literature. I mailed her, I only wanted her to read them and come today. She said she couldn't read them. She printed them in the morning and she didn't read and come. So that is too much for me. I am sitting and doing review for them, which I am not supposed to do, but she didn't even read and come. So this is my frustration but she started showing me crying eyes and red face, so I felt bad. Early morning I spoilt her mood. But my expectation is too high because her speed of reading is not that good. Or maybe language ability is not that good. Or whatever is the reason I do not know. So commitment is not there or the ability is not there. Maybe ability is not there, because when you don't have ability only then you feel like crying. So I am really trying to pull them up. Too much, I feel. Some of them are saying that in very less time I want them to pick up a lot. Because they are postgraduate students. I want them to at least come up to the level of my undergraduates. So then only they can go forward. So I am very tough in the beginning. I am very tough.

Me: So do you sometimes have postgraduate students who, you feel, are performing at a lower level than your undergraduate students?

Dr T: [Nodding] Because come in through a very difficult screening system, but still because of quota and other things they have entered the system, but now we really push them, push them, push them.

Dr T was speaking of her postgraduate students, all of whom had passed an even more competitive entrance exam than that taken by MBBS applicants, making the differentiation between marks even tighter. Nevertheless, Dr T's experience of the difficulties her student faces with the tasks she is set is understood through the prism of rank (see chapter 4). The significance of rank in the exam is exaggerated as a means of encoding disadvantages that actually have relatively little bearing on exam performance but become visible when students are

expected to perform tasks – such as speed reading and English comprehension – that neither their schooling, MBBS, nor exam coaching has prepared them for.

There is obviously no easy remedy for the consequences of generational disadvantage as they manifest in higher education. When I raised the issue of the narrow nature of the MBBS entrance exam with Dr D, he argued that were it to be broadened to include elements such as an essay and an interview, students applying through reserved categories – in particular those from the least privileged backgrounds – would be at an even greater disadvantage.

In her individual effort to compensate for the cumulative disadvantages that stymied some students in their effort to learn, Dr T evinced a sense of responsibility – even if largely motivated by concern for her own reputation – that AIIMS appeared to lack as an institutional principle. There was no comprehensive institutional investment in helping students fulfil their potential, she said, because with a pass mark of 50%, there was little concern about anyone failing altogether.¹⁴⁶ It begins to seem that if the moniker ‘coaster’ has any applicability at AIIMS, it is not to a group of students, but to the institution itself.

Fifty percent is not a difficult thing. I don't think it is difficult because we have a lot of opportunities, lot of classes, lot of seminars, lot of conferences, library is very good. They can attend any programme, anytime, anywhere, so that way fifty percent I think everybody will get because already the cream of the country is here. Fifty percent all of them will get but it is our problem that we want all of them to be in really good bracket. Very good bracket. ‘Good’ does not satisfy. ‘Very good’ only satisfies us. Very good and excellent.

By including all AIIMS students in her reference to ‘the cream of the country’, Dr T reminds us that this is a conversation highly specific to this unique institution. And while frustrated with the system, she recognized the distress experienced by students as real, and as more likely to reflect a struggle to manage the demands placed upon them, than a lack of commitment.

¹⁴⁶ Recall Deshpande’s (2013b) argument above that the high standard of the entrance exam ensures that most students will succeed with little institutional support.

Dr D was pleased that the introduction of the OBC reservation had led to a more diverse student body, but he also observed the hurdles faced by students who found themselves in a more challenging academic, and social, environment that they had previously been exposed to:

...though they come on the basis of reservation, they have to have certain level of performance in examination. So when they come from...in their own milieu they are probably fairly high on scholastic achievements, but once they all land up in AIIMS the people who are coming from general category are far more, their performance is far much better than the other ones. And therefore there is a constant stress upon those who have come through reservation to prove themselves. Some of them have not been able to deal with it and I know few who left in between, others who wandered into substance abuse and such things.

The ‘hypervisibility’ of caste that Deshpande (2013a) discusses is again pertinent here, where students in reserved categories are understood to possess particular characteristics that differentiate them from the meritorious standards set by the members of the general category. SC/ST or OBC students become ‘them’ – understood as a group, with occasional individuals who may defy type and expectation.

It has happened. I think it has happened with the effort of the teacher only. Teacher has pulled them so much so they have outshined, they have outshined the 12th rank. It has happened. But a lot depends on the...both sides. You are pulling up but the student is also equally running with you. Both are running. If both are running then it is possible that they will outshine the higher rank person. They can outshine. They have done it. They have done it. Two of my students are doing PhD now, and everybody wonders that what we did to them that they became so good. And they were lowest ranked people. But they were also running with me – only then. Like I am pulling, pulling, so they also work that much hard. – Dr T

This trope, in which a member of a reserved category defies type and expectation by excelling, is also deployed to deflect suggestions of institutional casteism or the naturalization of attributes pertaining to a particular social group. When I spoke to a former senior member of the AIIMS administration, he pointed out that SC/ST candidates often ‘become better than others,’ and

that ‘many are already brilliant on arrival.’ He cited the SC identity of a highly-respected head of department as a case in point.

Four students from reserved categories have committed suicide at AIIMS in the last six years. While denied meritocratic recognition, their capacity for single-minded determination and application is made clear by their, horribly brief, presence at AIIMS. We have seen in this chapter that managing the MBBS is, for some students in reserved categories, a matter of chance. In many cases, a middle class upbringing with a relatively high standard of English medium schooling equips students with the cultural capital and habitus that is as necessary as a talent for mugging-up to benefit from an education at AIIMS. In a few cases, the absence of these pre-requisites might be recognized by a faculty member willing to invest time in helping a student reach her potential. And in others, a struggling student may be met by an institution that appears indifferent, and feel left with no option other than to effect the ultimate erasure of ascribed identity through self-destruction, in the shadow of the country’s most highly regarded public hospital. The tragedy of these extreme cases, where the pursuit of knowledge to preserve life ends in death, throws into sharp and disconcerting relief some of the themes of this chapter. The transformative possibilities of AIIMS as a liminal space are denied these students; their deaths expose the underbelly of a celebratory discourse of freedom that might otherwise be experienced as neglect.

‘Chaotic confrontations’

Subramanian’s (2015) analysis of the embeddedness of merit in upper caste identity is heightened by her focus on IIT Madras and the specific cultural histories of Tamil Brahminism. AIIMS, while predominantly North Indian in its composition, does not cleave as tightly to a regional institutional identity, and thus does not reflect the sort of local caste dynamics that Subramanian depicts,

or that Purush and Priya described in Rajasthani institutions.¹⁴⁷ What this does open up, however, is the possibility for regional allegiances among students.

Me: Some students have said that because AIIMS is an All India Institute, the allegiances are more regional than caste-based...

Priya: Yeah, actually, that's very true. We have a group of Keralites, and they talk in some language we don't get at all! So we feel out of place like that...but yeah caste is very less, it comes down and, yeah, language goes up.

Priya's description of regional cleavages taking precedence over explicit caste groupings was common among the students I spoke with. Anjali pointed out the factional dynamic when she mentioned a party being organised by the interns. Only the North Indians would go, she said. 'The Keralites are invited, but they won't come'. In my observations too, the Malayalam-speaking students from Kerala tended to stick together (Hari said he was reassured to find so many fellow Keralites at AIIMS), but not to the absolute exclusion of their classmates, with whom they spoke more Hindi than English.¹⁴⁸ Santosh agreed that regionalism trumped reservation in a way that distinguished AIIMS from peripheral colleges, and he explained how the regional fractures became visible in student politics. The Keralites and Punjabis were 'enemies', he told me, but, in an apt microcosm of national politics, they formed a coalition in order to win control of the Students Union – an outcome that made the national news in 2015 (James 2015).

Purush argued that linguistic divisions were 'quite natural,' and that not everyone cleaved along regional lines. There was, he said, a variety of 'chaotic confrontations' that diluted caste and reservation as the main differentiator of students: region, language, those going to the US versus those not – these were all themes. But he considered class and upward mobility to be the most significant leveller among the student body. 'Now there are no binaries,' Purush

¹⁴⁷ This is another reason to observe the development of the new AIIMS in coming years. Will they develop more specific regional identities and might this be accompanied by more overt caste politics among students than those currently evident at AIIMS Delhi?

¹⁴⁸ The students from beyond India's Hindi heartland (see map in chapter 1) have the additional task of improving their Hindi skills in order to communicate effectively with patients. Some teachers were more understanding than others about this challenge.

said, and suggested that there was a common middle class habitus that the large majority of AIIMS students had in common, regardless of their category affiliation. It is a revealing argument, leaving me to ask whether the primary reason for less overt discrimination at AIIMS than elsewhere is that access is largely denied to India's most deprived young people. On one hand, this allows AIIMS to unjustifiably claim superiority over other institutions more troubled by caste conflict, while on the other suggesting that much greater scrutiny is required of the discrimination that *does* occur in the elite institution.

Of all the students I spoke with, it was Purush who most embodied the transformative potential of AIIMS as a liminal space. In his original conception, Turner (1967) notes that in the liminal situation neophytes are relieved of the responsibility of specific social roles and are able to 'confront one another, as it were, integrally and not in compartmentalized fashion as actors of roles' (101). 'For a while,' he goes on, 'there was an uncommitted man, an individual rather than a social *persona*, in a sacred community of individuals' (108, original emphasis). Reflecting from a contemporary standpoint, Thomassen writes that 'Turner realized that liminality served not only to identify the importance of in-between periods, but also to understand the human reactions to liminal experiences as they shape personality, suddenly foreground agency, and (sometimes dramatically) bind thought to experience' (2015: 46).

I observed some of this in Purush over the course of our conversations, as he tussled with questions of identity and allegiance. 'It is important to find your individuality,' he told me. He didn't feel responsible for an SC community: 'I was just born into it.' And when we spoke of suicides at AIIMS, he said that they weren't necessarily linked to reservation, that people had personal issues for which they lacked support, before adding that, 'caste will always be a factor, until it is annihilated.' If he had to choose a dividing line, Purush said, he would split people into 'stupid versus non-stupid.' At AIIMS, he said on another occasion, 'ideas matter more than identities.' For doctors in particular, 'identity matters less,' he said, because 'everyone is a potential patient.' And in an exquisite allusion to the transition in which he and his peers were engaged, he

said that ‘doctor’ itself was a new identity, with its own status and reputation, which would supersede all others. With this vision, Purush presented the potential of the liminal state at its most ideal and powerful. While Mihir’s concern, above, about the ‘incompetent’ doctors produced by reservations illustrated almost the opposite. There is a poignancy about this distinction. Turner himself almost anticipated the experience of someone like Purush, challenging the boundaries of what society will allow him to become:

Liminality is the realm of primitive hypothesis, where there is a certain freedom to juggle with the factors of existence...But this liberty has fairly narrow limits. The neophytes return to secular society with more alert faculties perhaps and enhanced knowledge of how things work, but they have to become once more subject to custom and law...they are shown that ways of acting and thinking alternative to those laid down by the deities or ancestors are ultimately unworkable and may have disastrous consequences (Turner 1967: 106).

*

‘There’s no equality in the country,’ Dr A said, when I raised my questions about reservations with him. ‘How can there be equality in the institution?’

In this chapter, I have aimed to heed Adams and Kaufman by illuminating ‘the centrality of structures of power and the social relationships and enactments that render the consequences of those structures invisible in the formation of health professionals’ (2011: 315). I began by presenting students’ experiences of competitive dynamics within AIIMS and how these are, in a majority of cases, less pronounced than anticipated. This led to a discussion of the discourse of ‘freedom’ that many students celebrate about their time at AIIMS, and how (following Turner 1967) we might understand the institution as a liminal space of transition for students in the process of becoming doctors. Reservation-based difference and the discourse of merit refracted through rank, I have argued, act as a powerful lens through which to understand the possibilities and limitations of this liminal site of transformation.

I have written of AIIMS neither as an oasis of exceptionalism, an institution insulated from the fissures of social difference, nor as an environment convulsed by the violence of discrimination, but rather as a place in which the dynamics of reservation-based difference slip in and out of sight and experience – of students, of faculty, and of the researcher processing her field notes and interview material. It has proved important to understand the influence of other determinants, particularly class and its accompanying habitus, on student understandings and experiences of reservations. Prompted by the comments of Purush, I have asked whether it is ultimately the exclusive nature of AIIMS that both discourages a more overt caste politics among students, and impedes the kind of institutional reimagining that we might imagine a string of student suicides should provoke. These deaths, I have suggested, illuminate the darkness within the more often celebratory discourse of student freedom at AIIMS, offering an extreme illustration of the limits of liminality at a prestigious institution.

CHAPTER 6.

‘THE CLOSED WORLD OF WORDS’¹⁴⁹: COMMUNICATING MEDICINE

The arcane knowledge or “gnosis” obtained in the liminal period is felt to change the inmost nature of the neophyte, impressing him, as a seal impresses wax, with the characteristics of his new state. It is not a mere acquisition of knowledge, but a change in being. His apparent passivity is revealed as an absorption of powers which will become active after his social status has been redefined in the aggregation rites. (Turner 1967: 102)

What kinds of people are formed through contemporary processes of clinical training, and how do these evolving subjects transform health, power, and other aspects of social life? (Holmes et al. 2011: 105)

In the previous chapter we learned that for many students AIIMS was less challenging an academic environment than they had anticipated. We also saw how for some students the ‘freedom’ of AIIMS was a liberating experience, while for others it was more ambivalent, and in a few cases it became dangerous. In this chapter, I interrogate this theme further by focusing on students’ experiences of teaching at AIIMS, wherein the ambiguities of independence and what it means for the Institute to be ‘the best’ again become apparent.

Rather than analyze the overt content of the MBBS, I go on to consider what is *not* explicitly taught at AIIMS – specifically, the methods and implications of communication in the clinic. I use the broad term ‘communication’ not least because it is the most common descriptor of clinical interaction used by students and faculty at AIIMS. Analytically, I deploy it in a capacious sense, as a means of approaching the ‘socially charged life’ of language (Bakhtin 1981: 293), and the power relations ‘deeply embedded...within everyday social and linguistic interactions’ (Ahearn 2012: 264; Bourdieu 1991; Foucault 1994b).

I explore lack of overt attention to communication at AIIMS through the concept of the ‘hidden curriculum’ (Hafferty & Franks 1994). If we continue to follow Turner (1967), cited above, in thinking of AIIMS students as neophytes in

¹⁴⁹ (Foucault 1994a: 115).

the process of being initiated into a medical community, then what might the implications be for the question posed by Holmes et al. (2011), also cited above, of a system that relegates the study of language and communication to a reliance on osmosis and mimesis?

In the course of our conversations, students revealed a dual narrative about the large numbers of patients at AIIMS, who are simultaneously considered a burden and an educational asset by virtue of their presence at the hospital. I interpret this by positing the concept of ‘patient labour’. Bearing this in mind, and reflecting on a series of ethnographic vignettes from my time on the wards and in outpatient clinics at AIIMS, I suggest that communication offers the most vivid example of the porous boundaries of the institution, with consequences for how students learn (or do not) about structured difference, power, and what it is to be a responsible patient and a good doctor.

‘You can build your own brain afterwards’

I began this thesis with a question asked by Dr E during our first conversation, which I carried in my mind throughout my fieldwork: ‘Is AIIMS a university with a great hospital attached, or a hospital with a medical college attached?’ Dr E had first arrived at the Institute as an MBBS student several decades earlier; when we met in 2015, he was a highly respected member of senior faculty. His personal lament for ‘the loss of university character’ at AIIMS was laced with both sadness and frustration, even as he acknowledged that standards of clinical care had improved. ‘Ours was a period of romance,’ he told me in his office. ‘It was all about the students.’ As emphasized in Rajkumari Amrit Kaur’s speech to Parliament in 1956 (see chapter 3), the residential campus was intended to enshrine an ethos of *guru-shishya* – India’s indigenous education system based on a close relationship between student and teacher – at the heart of the institution. The wife of the first director would invite undergraduate students to their campus bungalow for dinner, Dr E recalled. The third director made an impression by assuring undergraduates that they could ‘walk into his office at any time.’ And in the early days, Rajkumari Amrit Kaur would stroll around the

campus, interacting with students and observing the institution that she had been instrumental in creating.

With expansion had come de-personalization, which had detrimental ramifications for students, and had also, through the emphasis on individual departments, led to an erosion of institutional cohesion. The variable commitment to teaching was a concern for Dr E, and stemmed, he suggested, from the tendency of the Institute's senior management to rest on the laurels of reputation, at the expense of self-assessment and strategic vision. Reflecting on a period as director, Dr V complicated this view:

I was not able to do the things that in hindsight I should have done because I didn't have the management skills. If I had the knowledge to fight the bureaucracy I would have done much more. But whatever I had was my own intuitions. I had run a department for a while before I took over the directorship. But that was about all; I hadn't run the whole institution. Even if I had a vision, I didn't know how to execute the vision because of a lack of skills to fight the bureaucracy.

Nevertheless, Dr E said, 'now the MBBS programme is on the fringes'.¹⁵⁰

Students tended to agree. Neha's spoke directly to the freedom discourse raised in the previous chapter, illuminating its ambivalent consequences for learning:

AIIMS is better than other colleges I think...it depends. Actually in other colleges they spoon-feed you, they teach you all the stuff, they make you write the notes. Here we are very independent. We can study any of the books we want. In other colleges they have some prescribed books, like OK, you are supposed to read this only. Here we can experiment and do...that way I find AIIMS very nice, we are given full freedom to read whatever we want to. But...mixed. I think that they don't give that much attention to the undergraduates. Like it is basically for the postgraduates. And I think we are the neglected lot. And some of the professors are not very interested in teaching us. And I think whatever we study, we study on our own. The practical experience is very nice, you can go to wards and you can learn about new cases. But I find the class is not that interesting. I think that in my school days, the classes were more interesting. And medicine can be very boring if you don't teach it right.

¹⁵⁰ T.N. Madan reports being told in the 1970s that a 'smugness' had overtaken the teaching programme. 'The Institute has a split personality,' he was told, with some faculty members in favour of scrapping the MBBS altogether (1980: 82).

Several students were disappointed by a lack of engaging practical training. 'It's OK, but I expected more than this. I wanted to learn more, like more interactive sessions, case discussions with the professors...this is not going well,' Ugyen told me. Ashish agreed; he felt that the standard of instruction had deteriorated during the course:

I find it quite theoretical. So it would be better if we would have more case studies to discuss and all. We had it in our second and third years. But this year so far has been quite uneventful. Not uneventful, it has been...I don't know, dull.

For those comparing AIIMS with the idealized image that fuelled their application, the Institute regularly fell short. Not everyone was dissatisfied, however. Although, as suggested in the previous chapter, the most glowing assessments of the AIIMS academic experience came from students who compared it with less prestigious colleges. Nikhil exemplified this position:

Our pattern of teaching is so good. When I compare with my friends, who are doing MBBS in peripheral colleges, I ask them and I compare with my college, our college is so focused on the practical things, along with theory, yes, the lectures are there. In third year, it was very good, I would attend my seminars, and seminars were so nice. Like there they give one topic, like coronary artery disease and the faculty from surgery, paediatrics, they all come...and it is so wonderful. I ask all my friends and there is nothing like that in the peripheral colleges, no such thing is happening. So the practical things are very nice...It is still very exciting and I think I am not even able to use all resources at AIIMS. I am doing well but I still think I should use more opportunities...There are so many conferences going on every day, one after the other. So this is the best thing, if you want to you can attend them.

We saw in chapter 4 that a talent for memorization and mugging-up is crucial for winning a place at AIIMS. Several students expressed their frustration that these techniques remained central to their academic experience during the MBBS. The reliance on memorization, while necessary to an extent, was deemed excessive, and symptomatic both of a lack of pedagogical excellence, and of the structural flaws in a system that had to be gamed in order to proceed to

postgraduate study, at the expense of the clinical experience that would prepare students to be confident doctors.

Sometimes you feel like pulling all your hair out because the textbooks are like that...it's not conceptual, in the end you have to memorize as much as you can. And whatever concepts they say there are, actually it is that you have memorized this much, now you apply ... It's a bit tedious. I'd say that the expectations which I had when I entered were quite academic in nature. I thought that there would be more stress on academics and teachers would be teaching us throughout the clock and that we would be learning things that no one else does in the country. But the academic culture here is not that good. – Mihir

Deepak explained how the legacy of preparing for the entrance exam continued to influence his study method at AIIMS, until one of his seniors intervened:

I was studying and all and everybody has a habit to read the book from cover to cover. We were doing that since two years for preparing...and my friend said, 'Why are you not reading those selected portions that seniors told us?' I said I don't believe in that thing, I'll read the whole book. And he said better to read those selected portions, it will help you in getting through the exam. You know, you can build your own brain afterwards...

This highly strategic approach to assessment didn't sit entirely comfortably with Deepak. When I asked if he passed similar advice on to his juniors, he nodded. 'But it's not like I mark it for them. I say that if you are reading a book, try to analyze that information rather than, you know, mugging up all the sentences.' I was unable to talk with Deepak again, but I wondered on reflection how he had arrived at the conclusion that analysis was preferable to mugging-up – or, why he was uncomfortable with the advice to defer 'building his own brain'. His own advice to junior students to think about the information they were reading, seemed an effort to inject into the MBBS experience the intellectual stimulation he found lacking.

Shankar's concern was about the emphasis placed on book learning at the expense of clinical experience, and the consequences this had for students graduating from the MBBS:

It should be more of you know more from books to patients, we are mostly reading books and learning books and it is not experiential. I mean we see patients but we don't see patients that much as we study books. We obviously see patients when we go to wards and all but...from books MCQs [multiple choice questions] will be asked...and so people they give more importance to each line of a book. [But] it is not important, because if you know the basic things you can always look up in MedScape...because the details keep on getting updated in research and reviews and all come up. So we don't look at [the whole] picture, we look at the details. So more of going to the wards, and more kind of... so that we can actually practise, we can actually become primary care physicians at the end of the MBBS.

These anxieties become most evident during the internship,¹⁵¹ the final year of the MBBS, the function of which has become a point of contention among students and faculty alike. With competition for a postgraduate (PG) seat even tougher than that for the MBBS, there is a tacit understanding among students and faculty that the intern year will be used at least in part for entrance exam preparation, particularly the final eight weeks during which students choose their departmental attachment.¹⁵² Shyam blamed this situation on the theoretical emphasis of the PG entrance exam – the greater attention to clinical skills was partly why he was planning to pursue further training in the US:

The competitive exam, which we have to clear for getting into a postgraduate program in India, we have to have a lot of theoretical knowledge. It's not the same as in the USA where you have to have good clinical skills too...if you haven't attended your clinics well, you are not bound to do very good in those exams. But in India it's much more of a theoretical paper. There is just one paper, one day, everybody gives that paper simultaneously. There are 200 MCQs, you solve those MCQs, the result comes on the basis of that. And boom, you are selected. So the person who sits in the room most of the time and reads the books instead

¹⁵¹ The internship is designed to provide twelve months of clinical experience to students according to the following rotation: medicine (six weeks), surgery (six weeks), rural posting to Ballabgarh (twelve weeks), paediatrics (four weeks), obstetrics and gynaecology (four weeks), casualty (four weeks), anaesthesiology (two weeks), ophthalmology (two weeks), choice of elective (eight weeks). See here for the complete MBBS syllabus: http://www.aiims.edu/aiims/academic/courses_syllabus.htm [accessed 21/07/16].

¹⁵² On this topic, Madan wrote in 1980 that: 'some interviewees questioned the wisdom of dispensing with examinations after internship. They maintained that Indian students are examination oriented and the majority of them do not take internship seriously' (81). An argument for a pan-Indian MBBS exit examination is currently being advanced by those concerned by the variable standards of medical education in the country (Rao & Naik 2016).

of going to the college, he scores the most. So obviously, why would people want to go to the college?

The consequences of this are not unique to AIIMS – there is a broad recognition throughout Indian medical education that the development of clinical expertise among MBBS students is undermined by the pressures that the PG entrance exam places on the intern year.¹⁵³ For some students, the study treadmill resumed long before the final year. Nikhil told me that one of his seniors had asked him at the start of his second year whether he had begun PG coaching yet. ‘I was like, no, not yet! I have just taken a prof examination, I want to take things coolly after so much studying...’

The tension between these two imperatives is confirmed in an interview on a coaching website with an AIIMS PG entrance exam topper who notes the ‘mistake’ of prioritizing the internship over exam preparation:

The mistake I did during my MBBS and internship days is to let the golden moments pass. I did not prepare during internship. I was enjoying my first days and first experiences as a doctor. My good friend...told me during my internship, ‘If you attend medicine postings too much, you are not going to get medicine in PG.’ While at the time I did not pay much heed to those words, but how true they were. It is very important to develop your clinical acumen during internship because after all, you are going to be a doctor. But for the unfortunate situation in our country, we need to devote the final years of MBBS and internship which is better spent learning clinical skills, to prepare for PG entrance. I loved the internship, didn’t read at all but it made me lose a year. I hope no one does the same mistake.¹⁵⁴

Some students felt that this system had also been internalized by faculty, with the result that interns were not given sufficient attention. Shortly before we met for an interview, Shyam had written to the director, complaining about his treatment as an administrative dogsbody and demanding that interns be given more opportunities to gain serious clinical experience (he had not received a reply by the time I left Delhi two months later). Anjali had little patience with

¹⁵³ Dr Raman Kumar, personal communication, 9/3/16.

¹⁵⁴ <https://pgblazer.com/aiims-pg-topper-interview-dr-shuvadeep-ganguly-10th-rank-november-2015/> [accessed 21/07/16].

faculty complaints about intern absences. ‘What do you expect?’ she asked; few students could afford to take unpaid leave after graduating and so they had little choice other than to study during the internship. ‘That’s the way the system is set up,’ she said.

Students acknowledged the pressures on faculty, citing huge number of patients and the demands of research as reasons why they did not prioritize teaching. Mihir suggested that a reluctance to teach was informed in part by the reluctance of students to attend classes. This seemed to have become a self-fulfilling situation, at least among the senior students, who had not internalized the new attendance requirements, confident that they would pass as long as their attendance didn’t drop below 50%. Anjali thought that the neglect of undergraduates was inevitable given these pressures, but suggested that assigning teaching to faculty members committed to education would be a means of ensuring a more reliable standard. ‘Because I’m sure a lot of professors just take teaching as an add-on which they don’t really want to do, but they have to do, and [they] do it in a very...there is a special word for it, it’s called *jugaad*.’¹⁵⁵

It was not only students who complained about the uneven quality of teaching and unimaginative pedagogy at AIIMS. We saw Dr E’s concerns above, and particular faculty members publish regularly on the need for curriculum reform and the impediments that prevent it, both at AIIMS and in India more broadly (Adkoli & Sood 2009; Ananthakrishnan & Sood 2012; Sood & Adkoli 2000; Sood & Singh 2012). During my fieldwork, the Centre for Medical Education and Technology (CMET) organized a voluntary three-day workshop on teaching methods for faculty. Those in attendance were mostly junior faculty who had recently joined the Institute, although a deputy head of department who had been at AIIMS for many years also attended and was enthusiastic about the opportunity to review and improve his own teaching practice, and at least one person had come from another medical college in Delhi.

¹⁵⁵ A form of improvisation, or making do, with whatever resources are to hand.

The workshop involved discussions of medical pedagogy, teaching and assessment methods. During the final feedback session, there was vocal appreciation of the workshop, but also anxiety that for all the encouragement to be innovative in teaching and assessment methods, the capacity of junior faculty to instigate change was constrained by hierarchical departmental structures. Some participants felt that without the support of their head of department, they had very little room for manoeuvre. I wondered to what extent institutional transformation was an eternal waiting game, as young faculty members were encouraged to innovate by a few of their seniors, while knowing that challenging embedded practices was unlikely to be the route to approval and promotion. Madan was told during his study that younger faculty members feared expressing disagreement, and that open discussion was impeded by hierarchies and rigid institutional structures (1980: 91).¹⁵⁶

What was the answer to this, I asked Dr E. He shook his head. 'We need good role models at this stage,' he said. 'Very badly.'

Communicating medicine

In this section, departing from Dr E's comment above, I consider the position of doctor-teachers as role models at AIIMS and the influence they have over what and how students learn. Rather than analyzing the explicit content of the MBBS syllabus, I consider its *implicit* – or hidden – content, with a particular focus on communication and its implications. Communication methods are not part of the MBBS curriculum. Students learn how to communicate with patients either through the implicit example or deliberate instruction of individual faculty members, and in doing so they learn both particular uses of language and the relational implications within it. Following Duranti, language is revealed 'not only as a mode of thinking but, above all, as a cultural practice, that is, as a form of action that both presupposes and at the same time brings about ways of

¹⁵⁶ This challenge is not unique to AIIMS, or India – see Turner (1987) on the bureaucratic evolution of British hospitals. Serious attention to this question would demand a foray into literature on organizational change that is beyond the scope of this thesis, but see, on the contribution of anthropology to the study of organizations, Wright (1994).

being in the world' (1997:1).

In the following pages, and in keeping with my broader theme, I show how language acts as a channel through which pass the determinants of social and medical power that influence the doctor-patient relationship, and students' impressions of exemplary medicine. My analysis speaks to the two citations at the opening of this chapter, from Turner (1967) and Holmes et al. (2011) respectively, as I consider how neophyte doctors are influenced by a hidden curriculum (Hafferty & Franks 1994), and the consequences of this training for the future practice of India's 'best' clinicians.

'The least you can do is listen to us'

In November 2015, the Department of Official Language in the Ministry of Home Affairs instructed the administration of AIIMS to ensure that all official documents and stationery used at the hospital be printed in both English and Hindi (Bhatia 2015). Ostensibly, this directive was motivated by a concern to make the AIIMS experience more intelligible for patients with little or no English, despite the pre-existing bilingual signage and stationery. Any denial of political motivation seemed belied by the overt policy of the BJP government to elevate the use of Hindi in governance (ibid.), but the more spurious argument was that by increasing the use of written bilingual terminology a patient would be less befuddled by her experience of the hospital.

The idea that direct translation would provide illumination is undermined both by the fact that many AIIMS patients have only limited literacy and rely on oral rather than written communication for understanding, and that few technical medical terms in English have an equivalent in the colloquial Hindi spoken by most patients. By extension, the proposal missed the way in which many English biomedical terms have been absorbed into the vocabularies of low-income patients. As Veena Das notes in her work on ecologies of care in low-income neighbourhoods of Delhi, terms such as 'X-ray', 'CT scan' and 'ultrasound' are part of common parlance, fed in significant part by the 'paradox

that in the poorest localities one can find advertisements for the most sophisticated technologies' (2015: 21).

Medical anthropologists have long noted that medical terms come to contain their own meanings that relate to the socio-cultural and political-economic context in which they are experienced and expressed (Cohen 1998; Good 1977; Kleinman 1988; Lock & Kaufert 2001; Scheper-Hughes 1989). Thus, a reference to diabetes in its formal Hindi translation as *madhumeḥ* empties it of the meanings contained for many patients in its moniker as simply 'sugar'.¹⁵⁷ Similarly, directing a semi-literate patient to the gastrointestinal surgery department by referring to *jatharaantra sarjaree vibhaag* rather than the appropriate *manzil* [floor] of the *laalvali* [red] building, is extremely unlikely to remedy a patient's sense of dislocation at AIIMS, which stems predominantly from the spectacular power differential that exists between her and the medical institution.

The recent compilation of Veena Das's (2015) longstanding work is an invaluable means through which to gain insight into the low-income neighbourhoods from which people are occasionally 'propelled' in search of more effective care. Many of the hospital patients Das writes about 'experienced bafflement' about administrative procedures and documents, before they even saw a doctor, who they then found was unable to 'hear' them (ibid.: 221–222; Lazarus 1986).

Disrespectful and degrading behaviour towards patient by doctors has become part of the conventional wisdom surrounding perceptions of public healthcare in India¹⁵⁸ (Chattopadhyay 2015; Pinto 2010; Ram 2010; Van Hollen 2003; and see Andersen 2004 on a similar discourse across the African continent). Ram suggests that 'the scolding lecture' that takes place in the clinic be considered a genre of its own, exemplifying the 'social contexts and practices

¹⁵⁷ Those patients who do use the term diabetes are also unlikely to gain anything from a doctor referring to it as *madumeḥ* beyond a new addition to their Hindi vocabulary. The film *Chupke Chupke* (1975, dir. Mukherjee) offers a comic example of the alienating outcome of the deliberate use of very formal Hindi.

¹⁵⁸ This is not to suggest that communication in the private sector is unproblematic. See Datye et al. (2006).

in which medicine can, and does, operate as a mode of class distinction' (2010: 206; Andersen 2004).

At AIIMS, patients' complaints were predominantly about administrative inefficiency and long waiting times. Doctors rarely came in for direct criticism¹⁵⁹, and sympathy was often expressed for the workload doctors faced given the large crowds. According to most of the patients I conducted brief interviews with as they waited at various spots around the hospital grounds, the generally courteous behaviour of AIIMS doctors distinguished them from those at other public hospitals. Two men from Delhi said that, 'the doctors here are very well behaved. There are some problems here, there is a lot of crowd that comes, and the public too has to face some problems. But mostly it's excellent.' A young man who had accompanied his aunt on her journey to AIIMS from Bihar spoke along similar lines:

The doctors are fine. They are good in every respect. They talk nicely. Here crores¹⁶⁰ of patients come, and someone might get cross with the patient but that is not the case here. They give their time and are compassionate. Every single person says that, yes, we went to AIIMS and the doctor behaved very well, and treated very well. That is what the patient remembers after everything. Everything else is in the hands of god.

Nandini, a young mother who had brought her toddler to AIIMS from Bihar for an operation, had only positive things to say about her experience. In particular, she emphasised that she felt comfortable asking the doctors questions and that they were happy to explain things multiple times if need be.¹⁶¹

Some people troubled these accounts, however. Sharmila, a young woman who was at AIIMS for a consultation following a kidney transplant, pointed out that the majority of patients would be comparing AIIMS doctors with those at other government hospitals. There was no question of their superiority on that

¹⁵⁹ I am conscious that some people may have self-censored out of intimidation by the institutional setting, and uncertainty about the motive for my questions. My research assistant Preeti and I regularly had to assure patients that I was not a representative of AIIMS.

¹⁶⁰ One crore is ten million.

¹⁶¹ This patient's contentment with her experience was mirrored in the assertion of several students that the best teaching took place in the paediatrics department.

front, she said, and on the whole she found the behaviour of AIIMS doctors fine, particularly if one discounted their occasional impatience provoked by overcrowding. In comparison with the private practitioners she had seen, however, Sharmila found some AIIMS doctors wanting¹⁶². She recalled one incident in particular, which vividly illustrated the porous boundaries of the institution, through which leak attitudes and perceptions that stand at odds with the ideal of the hospital as a ‘culture-free’ island of biomedical rationality (Andersen 2004; Taylor & Wendland 2014):

It happened once. I’m a Muslim and my kidney donor was Hindu. She was my friend. So, repeatedly the doctor would say to me how come there is such friendship between a Hindu and a Muslim. He used to torture me with this. He was not a senior doctor, he was just a junior. One day I got really angry and I said to him do you also need a kidney? I’ll get you one, I have other friends. I was very angry, and I said despite being so educated why do you have such discriminatory behaviour? He apologized and said, no, Auntie, why are you getting angry? I said, no, a person jokes once, not ten times about the same thing. After that day, that poor doctor was also embarrassed, and then behaved very well with me. I think he got scared that I would take it up with the higher authorities. He got very scared with me then, and continued to behave very nicely. He left here eventually.

Sharmila went on to praise the senior nephrologist who had treated her at AIIMS, and with whom her family exchanged greetings on Eid, Holi, and Diwali.

Without wanting to strain my analysis on the basis of a single experience, I would suggest here that it is not coincidental that the two distinct attitudes Sharmila faced divided along generational lines. Jacob Copeman (2009: 149–168) and Lawrence Cohen (2004, 2005) have each demonstrated how, with important exceptions, the discourse around corporeal donations – of blood and organs in their respective work – continues to express a Nehruvian imagery of national integration even as such a vision has fallen out of fashion in broader public life.

¹⁶² On hearing such comments, it is worth recalling the large and diverse nature of private practitioners in India. Given the severity of Sharmila’s condition, it is likely that she is talking about doctors in high profile private hospitals rather than local clinics. As Das (2015) notes, little anthropological work exists comparing quality of care and patient experience between the public and private sectors in India. Much more research is called for on this front in order to problematize simplistic public/private dichotomies.

Copeman describes how ‘high-minded doctors’ broadly Nehruvian commitment to national integration’ through blood donation is perceived as being ‘under threat’ from growing materialism¹⁶³ and the politics of Hindutva (ibid.: 167). Sharmila’s account of the junior doctor’s behaviour, against the backdrop of a classically Nehruvian institution, while anomalous among patients I spoke with, suggests that a secular attitude that considers inter-religious corporeal donation an act of national integration is not guaranteed. If my argument that AIIMS is permeated by external social realities is to hold, then we must assume that changes in the external landscape will be reflected within the institution – as we saw with the politics of reservations in the previous chapter. As the national political discourse hardens around Hindutva, it seems logical to anticipate that its ripples will infiltrate institutional space, with consequences that will (further) puncture any image of an ‘ideal,’ implicitly Nehruvian, AIIMS doctor.

Of the patients we spoke with, Gita, a middle-aged woman who I met sitting outside the main OPD one afternoon and later visited with Preeti at her two-roomed home in west Delhi, seemed the most irredeemably dissatisfied with her treatment by doctors at AIIMS. Gita had been receiving treatment at AIIMS for fifteen years, and she told us that the behaviour of doctors had deteriorated in that time. Their refusal to conduct an operation that Gita deemed necessary had left her feeling neglected and misunderstood. Notably, her positive recollection of her original AIIMS doctor was associated with the fact that as well as speaking respectfully, she had benefited from his treatment. This speaks directly to Das’s findings among low-income Delhi residents that effective treatment depended on a combination of harmonious relations with a doctor, plus that the prescribed medicine ‘take’ on a person [*unki dawai mujhe lag jaati hai*] (2015: 217).

The doctors that used to be there 15-16 years ago were good. The present batch isn’t so good. They scold nowadays. I go and complain that I have bodyache, joint-pains, and I have difficulties walking, they just say that what can we do, we have prescribed the medicines, go home and rest. They refuse to operate saying it isn’t a big deal. Many times they behave

¹⁶³ Also see Baru (2010) on this theme with a specific focus on retired AIIMS doctors.

very badly. I sometimes addressed them as 'beta', seeing that they are younger to me. But they immediately retaliated saying we are not your children. They scolded me. They don't talk nicely. Only [Gita's first AIIMS doctor] used to talk nicely, he understood well. His prescriptions also worked well for me.

It's difficult. They should behave well, and should behave the same with the rich and poor alike. We are anyway in pain; the least you can do is listen to us, irrespective of whether we are rich or poor. If you talk politely, the patient will be reassured. They shout and scold a lot, even at the slightest mistake in diet. They scold. That is the biggest shortcoming, their manner of talking. – Gita

On two separate occasions we met a young woman, Sunita, in the main OPD. She was very distressed about her sister's deteriorating kidney condition and she offered a complex assessment of her AIIMS experience. As she spoke she seemed torn between sympathy for doctors and a tentative assertion of the rights of the patient and her family:

Too many patients come here. When there is an overload of patients, then they deal accordingly. But overall it's fine. The doctors are compassionate, their behaviour is good, and they are also thorough. But [in the Emergency department] I was pained because the doctors work so hard, look at you, treat you compassionately, but they also think, how much can we treat so many patients? But this is also there that when a patient is coming to you, then you are responsible for them, right? They don't talk. If you ask them they get irritated that you talk too much, you ask too many questions. They say they don't have time to answer useless questions, they say that look we are treating the patient, OK? The treatment is underway, so it's all fine. It's also probably our fault that we ask too much, to clear things or to ask their opinions. But sometimes we need to...

The students I spoke with considered language and communication an important dimension of medical practice. Shankar understood communication skills as part of 'professionalism', along with ethics and teamwork. With friends he had conducted a study during the previous year's Pulse:

So we had qualitative group discussions and questionnaire... and we conducted a study. So we asked them what they felt regarding why is professionalism not there, or what do they understand about professionalism, and why do they think it's not being taught, or should be

taught or not. So most of them felt that it should be taught in some manner or should be assessed in some manner, so there should be good role models and all.

Rahul, a fourth-year, was unhappy about the impatience of some doctors, and the way in which the patient load was blamed for this inadequacy:

[They should] teach people how to talk properly to a patient, that should be improved. I have seen a lot of doctors talking very...angry...I am not able to express myself...they don't talk to a patient as a human being, they just come and write. I know there is a lot of load, but still some time should be given to talk to the patient politely. History-taking is taught, like what you need to ask to a patient, but *how* you are going to ask the patient, that's the thing.

For others, however, the socioeconomic composition of the patient body inevitably – and necessarily – informed the nature of communication in the clinic. When we spoke, Shankar had recently returned from a semester as part of a research team at UCLA medical school¹⁶⁴. The differences between the clinical encounters he had observed in the US and those at AIIMS were fresh in his mind:

So the main difference was like the doctor [at UCLA] spends more time, 10-15 minutes. In the OPD for example, here everyone is there. But there [they have] patient rooms, so a patient sits in there. And then a nurse first takes the vitals and all, and then the patient is comfortably seated in the room and then the doctor knocks and asks what have you come here for, what are your problems. He explains to the patient in a very nice manner, spends around 10-15 minutes there. So that's what I think is different. And here we have more patients, more...so.

As Shankar spoke, the generic defence of time pressure compromising an ideal standard of behaviour revealed a more complex argument about the nature of the patient demographic at AIIMS.

¹⁶⁴ Several students I spoke to had undertaken research fellowships at US institutions. While these visits were not officially part of the MBBS curriculum, there seemed to be a tacit understanding between students and administration that allowed for a certain manipulation of the system provided that all compulsory examinations were still taken. AIIMS did not provide any financial support for these visits, some of which lasted for three months, so they were limited to students whose parents could afford the necessary funds.

...given the practical scenario where the patient's educational status is low, they are not able to understand, and then they ask lots of questions. So if you speak to them in a very polite manner then they will not leave...*sar pe chad jaate hain* [Hindi idiom meaning to be taken advantage of] and you have very less time. If you spend 5-10 minutes with everyone, you will end your OPD at night. And you have to end your OPD at 1pm. Because they are not, educational status is so low. So [doctors] can be more courteous but it also has drawbacks, the patients will say all this...but still I think [doctors] can be more courteous.

From this perspective, paying excessive attention to patients poses a risk to order in the clinic. While anticipating that patients with little education might seek clarity from doctors if given the chance, and recognising that these two social facts were interrelated, Shankar argued that the time constraints doctors operated under meant that they could not indulge patients' efforts to 'take advantage' of an opportunity to better understand their situation. The limits of a doctor's responsibilities (at least in Shankar's eyes) are made clear here. Maintaining communication at a tenor deemed appropriate becomes a means of disciplining a potentially unruly patient body, in the guise of temporal exigency. Sarah Pinto found a similar dynamic in her work on psychiatric practice in North India, in which an ethos of 'pragmatism' was understood as both 'a requirement in strained conditions and an ethic derived from *material* context' (2015: 7, original emphasis) and 'a matter of *cultural* context' (ibid., original emphasis).

As exemplified by Sunita above, 'pragmatism' by doctors can provoke a complex response by patients. What is objected to is not necessarily the brevity of the encounter, which is anticipated and which does not in itself preclude a detectable ethic of care and attention, as patients attested. Many patients also tolerated a degree of impatience by doctors, and were only discomfited when this crossed a line to become insult and degradation. At that point, tolerance becomes muddled with anxiety about the validity of chastisement, and further complicated by the doctor's failure to acknowledge the importance of a patient's questions about what is taking place in, and being enacted upon, her own body or that of her relative.

Agreeing with Shankar that different types of patients needed to be communicated with in different ways, Ashish was concerned that he would leave AIIMS at a disadvantage if he wanted to pursue a career in private practice:

Patient demographic here is mainly people from low socioeconomic background. So we don't get access to, we only know, I don't know how to say this but you know we talk to different kinds of people in different ways? So we only learnt that how to talk to people of low socioeconomic background.

What is missed in Shankar's scenario above, is that it is patients of higher socioeconomic status who, if any, 'take advantage' of doctors at AIIMS. At the extreme end of this spectrum are those whose access is so highly privileged as to allow a direct phone call to a doctor's office (such calls were often made in search of what Dr E referred to as a 'big ticket second opinion,' as he apologized for cutting short our conversation to answer the phone to the solicitor general), or being ushered in front of a head of department for a private consultation part way through an ongoing meeting.¹⁶⁵ Then come those who put their heads around the door of the consulting room part way through an OPD and plead in English with the doctor to add their card to the pile.¹⁶⁶ When their turn comes, it is these patients who attempt to engage the doctor for as long as possible, deploying biomedical vocabulary to establish parity of understanding and seeking opinions until the doctor succeeds in encouraging them out of the door. In one example of this dynamic, during an OPD in June 2014, a smartly dressed middle-aged woman persisted for several of Dr A's precious minutes in trying to convince him that her status as a public figure meant that refraining from colouring her hair as instructed was not possible. 'Not even a little bit of henna?'

¹⁶⁵ See Turner on the divergence of hospital organization from that of traditional Weberian bureaucracy: 'The hospital authority structure is fractured around the difference between the rational bureaucratic system and the professional autonomy of the doctor through a system of medical domination' (1987: 160). This point holds at AIIMS, evident in the enduring power of personal networks in accessing services.

¹⁶⁶ While Dr A tended to accept such requests with an air of resignation, Dr L had no patience with these methods, including those deployed by AIIMS staff. Her dismissal of such requests could be brutal and her disruption of a system of tacit privilege caused visible confusion. Even Dr L, however, was unable to insist that a senior faculty member join the queue like any other patient, although her frustration was palpable.

she tried, as Dr A shook his head and reached determinedly for the next patient's card.

Kalpana Ram (2010) has written about how the class confidence of middle-class patients in Tamil Nadu informs the doctor-patient encounter. Employing habitus as a means of understanding 'the ways in which the past flows through individuals, absorbed as a part of their repertoire with which they meet the challenges of the present, without necessarily being aware of every element' (204), Ram suggests that patient confidence is observable 'not only through the use of biomedical classificatory categories, but in the way of regarding biomedical spaces as, in some sense, an extension of one's own class habitus' (207-208). For these patients, I would add, the doctor's authority stems predominantly from a repository of medical knowledge;¹⁶⁷ the power expressed through a capacity to discipline and diminish is, if not entirely absent, at least challengeable in this encounter. By contrast, the combined power of biomedical knowledge and the social authority of class and profession often act as a silencer upon patients of lower socioeconomic status. Bourdieu's insights into communication are also valuable here, as he describes linguistic exchanges as 'relations of symbolic power in which the power relations between speakers of their respective groups are actualized' (1991: 37).

Inset: Patient labour

The extremely large number of patients seeking treatment at AIIMS each day – the 'heavy patient load' as it is referred to – and the pressure it exerts, is blamed for many challenges at the institution: overcrowding, time constraints, doctors' impatience, the neglect of MBBS students, and reduced opportunities for research. The primary reason for the overcrowding is generally held to be the inadequate public healthcare infrastructure across North India, coupled with the

¹⁶⁷ See Jamous & Peloille (1970, cited in Turner 1987) for their early argument that professions have to protect themselves against a 'routinization' of knowledge by protecting the hermeneutic dimension of expertise that ensures a power differential between client and professional (even with all other factors being equal). We might consider how this dynamic is expressed in relation to the role of the contemporary internet-empowered patient.

cost and variable quality of private treatment (see chapter 1). A growing penchant among patients for specialist treatment is also cited as a factor by some (see chapter 7), but on the whole there is a sense that most patients are forced through the AIIMS gates by structural circumstances beyond their control. Following Street (2014), we can understand the crowds of patients at AIIMS as engaged in ‘visibility work’ – ‘where bureaucratic and biomedical technologies are engaged with as relational technologies’ (13–14), rendering patients visible to an otherwise glaucomic state.

The challenge that visibility work on this scale poses to the functioning of the Institute is well-known, but a parallel narrative exists among students that the sheer number and variety of patients they are exposed to during their training is an *asset* that distinguishes AIIMS from other medical colleges. Krish encapsulated the way in which these dual narratives co-exist:

The crowd is not useful, but the type of patients is really useful. We are exposed to various rare diseases, and common diseases are also coming, but the rare diseases.... All these things they are just learning from books in our state, they have the diseases but it is not diagnosed there. But here I have seen almost 40-50 patients with SLE [Lupus] in 3-4 years. Many patients are here. All rare diseases are coming in, many syndromes are coming in. From a student’s perspective it’s good actually.

Ashish agreed: ‘Because you get a lot of cases, you get exposed to a lot of rare diseases, you get the whole spectrum of diseases.’

Compare these statements with that by the French psychiatrist Philippe Pinel in 1815, cited by Foucault in *Birth of the Clinic* (1994a) as he writes about how the unity of the hospital and the teaching domains became central to the development of clinical observation:

What a source of instruction is provided by two infirmaries of 100 to 150 patients each! ... What a varied spectacle of fevers or phlegmasias, malign or benign, sometimes highly developed in strong constitutions, sometimes in a slightly, almost latent, condition, together with all the forms and modifications that age, mode of life, seasons, and more or less energetic moral affections can offer! (107)

Vipul, a fourth-year, vividly illustrated an impression that patients sitting on the floor outside the main OPD are engaged in an act of citizenship by making themselves visible, or bioavailable (Cohen 2005), to the state for the purposes of education. For him, it was the educational utility of living human anatomy in place of synthetic dummies that gave AIIMS an advantage over Western medical colleges: 'In the West they mostly have dummies, they don't have real patients. They have dummies. Here we do get a chance on real patients and more exposure. That way it's an advantage, yes.'

Writing about the socialization of new doctors, Hafferty and Franks note how patients 'are cast concurrently as victims of disease, objects for learning, and subjects for research' (1994: 865). In his reflection on Foucault, Turner (1987) writes that '...the hospital transformed the sick patient into an object of medical training. The sick were to become useful as illustrations of disease. Since the sick were typically the poor, they also became useful in the fulfillment of science' (130). At AIIMS, an institution founded in the pursuit of science (see chapter 3), Balraj emphasized why it was important for students that many of the patients they saw were poor:

Yeah...actually useful in the sense that most of the diseases you see, I don't why, but those diseases occur among poor people. I mean those who are rich and well-furnished (*sic*), they just have those lifestyle disease, like diabetes, hypertension or all these type of diseases, or this excess fat. But most of the diseases, infectious diseases, malignant cancer, you see only in most of the times among these poor people. So it's better to see these people.

Students I spoke with during Pulse also cited patient diversity as a unique attribute that contributed to the superior reputation of education at AIIMS. A young woman from a medical college in Bihar suggested that state hospitals tended to see more locally prevalent diseases, such as Kala Azar in the case of her college, whereas AIIMS doctors treated a greater variety, with beneficial consequences for students. The value of an AIIMS MBBS comes to appear, at least in part, as a product produced by patients who enact their bioavailability in exchange for the hoped-for preservation of life.

In late April 2013, I went to AIIMS on a pre-fieldwork visit. One afternoon, as the temperature nudged 40 degrees, I noticed a young couple wedged into a small space between two families on a footpath. The couple lay on a patterned cotton sheet, facing each other. The man held one of the woman's hands between his, pressing it against his chest. They were beaming at each other. I couldn't discern who was the patient – whose need for treatment had compelled their journey to AIIMS. During that period, I anticipated my fieldwork being focused on how biological citizenship and relations to the state were enacted at AIIMS. I later wrote of this couple that their public intimacy and oblivion of those around them suggested that while they might have been denied affordable care at home, forcing them to spend meagre resources on a journey to Delhi in search of rehabilitation, their lives were far from 'bare' (Agamben 1998; Gupta 2012). And their bodies – engaged in the political act of claiming care from the state while offering their own care to each other – represented 'life itself' as beyond either the purely biological, or the experience of an undifferentiated biopolitical subject (Das & Poole 2006; Fassin 2009).

As this thesis attests, my fieldwork at AIIMS took me in a different direction, but in writing this section I recall the young couple on the footpath and see in their act of treatment-seeking at AIIMS not only their own biological claim upon the state (Petryna 2002), but also their contribution *to* it (Copeman 2009), as they make their bodies available for teaching and learning, augmenting scientific knowledge and thereby contributing to the fulfilment of the institution's original purpose. While Cohen has written of the operation as an opportunity 'to remake one's mindful body in accordance with the demands of developmental modernity, to remake one *as if* one were a modern' (2005: 87, original emphasis), what my conversations at AIIMS make visible is the way in which this process also informs the development of neophyte doctors into the country's 'best' – a description into which is coded an understanding of urban, technological modernity (see chapter 7).

Patients at AIIMS, then, are simultaneously a hindrance to efficient practice, and a bioavailable resource enhancing the institution's reputation for comprehensive training. The result of this exchange of educational labour for

medical treatment, however, has little impact on the conditions that compel patients to travel to AIIMS for attention. The large majority of students who benefit from this patient labour proceed to careers in private super-specialized practice, rather than working in the frontline care that, while it may alleviate afflictions that compel many patients' presence at AIIMS, is endowed with little social value, including by the Institute itself (see chapter 7).

As I wrote out these thoughts, I realized that Dr E's question about whether the institution is a hospital with a medical college attached or vice versa could be alternatively, and more simply, phrased as 'Who is AIIMS for?'

The hidden curriculum

Akin to the senior students' vague knowledge of new attendance requirements, Shankar thought perhaps some communication classes had begun at AIIMS, but he wasn't sure that they were compulsory. A former dean also told me that communication classes were beginning, but as I write, communication skills are not part of the AIIMS curricula. Therefore, any student learning in this capacity occurs through either implicit example or deliberate instruction by particular faculty members. This learning includes a tacit subtext about why certain styles of communication are deemed appropriate to certain patients and not others, and by extension, what it is to be a good or bad patient, and an effective doctor. In the remainder of this chapter, I draw on ethnographic material gathered from outpatient clinics and ward rounds at AIIMS to illustrate some of the ways in which the hidden curriculum operates.

While Cowell's (1972) definition of a hidden curriculum as 'that which the school teaches without, in general, intending or being aware that it is taught' is generally cited as the concept's starting point (O'Donnell 2014: 12), I follow Hafferty and Franks (1994) in their application of the concept to medical training:

Most of what the initiates will internalize in terms of the values, attitudes, beliefs, and related behaviors deemed important within

medicine takes place not within the formal curriculum but via a more latent one, a “hidden curriculum,” with the latter being more concerned with replicating the culture of medicine than with the teaching of knowledge and techniques ... Sociologically, medical training is the pathway by which lay persons are transformed into something other than lay persons – in this case, physicians. Neophyte students are taught what is valued by this new culture, along with strategies and techniques to organize these values. They are also provided with opportunities for internalizing these values. (865)

The ‘null curriculum’ (Flinders et al. 1986) refers to areas that are not attended to, or ‘lessons that are conspicuous by their absence’ (O’Donnell 2014: 14). One potential consequence of such absences is that students conclude particular issues, such as social justice or teamwork in O’Donnell’s examples (ibid.), are not sufficiently important to warrant specific attention. Ad-hoc efforts notwithstanding, language and communication are part of the AIIMS null curriculum, but this is made particularly complex by virtue of communication being at the heart of medical practice. To borrow from Taylor and Wendland (2014):

...The hidden curriculum in medical education, although it is right there in plain sight, remains effectively hidden because of the patterns of unseeing characteristic of medical education. In other words, the hidden curriculum helps create the blind spots in which it then hides (52).

*

Even when ten people fill the ten-feet square consulting room (in addition to me, on my plastic chair, tucked into a corner of the room beside Dr B, in front of the small sink, and beneath the tiny opaque window that suggests a distant external world), with an assistant trying to contain the hustle around the door¹⁶⁸, Dr B exudes an unruffled calm. His long experience reveals itself in an ability to maintain focused on the patient while reaching without looking for the relevant

¹⁶⁸ Following Hafferty and Franks (1994), O’Donnell notes how the hidden curriculum functions through space as well as speech. Thus, observing the AIIMS environment and the implications of how space is differently organized and maintained might be considered part of a student’s education (2014: 14).

form and ticking off the tests required, keeping the patient informed about his decisions, and reassuring them if necessary, before gently but firmly encouraging them to make room for the next person in the queue. This choreography is the technique of a veteran doctor's body (Bourdieu 1990; Luke 2003; Mauss 1935). I can see Gaurav, the most experienced of Dr B's senior residents, beginning to learn a similar technique. He is able to continue writing instructions for his own patient, while glancing up to comment on the shade of jaundice in the eyes of a colleague's patient. The contrast with the rabbit-in-headlights demeanour of the inexperienced MBBS interns is striking – their bodies have not yet learned. On the opposite side of the shared desk, another senior resident commands an elderly male patient to move seats. The brusque use of the informal register tum, rather than the honorific aap, emphasizes how class, professional status, and environment combine to confirm the power differential between patients and doctors. Tum can also connote affection in the clinic, but I only hear this in Dr B's voice, and usually only when he addresses a patient he has established a relationship with over a significant period of time.

*

One afternoon Dr B repeatedly asks an elderly man to explain his complaint in his own words. 'Aapko kya takleef¹⁶⁹ hai?' [What's the problem?] he asks, then shakes his head as the patient proffers a sheet of test results. 'Nahin – kya hai takleef?' This continues until everyone in the room, the patient included, is smiling. There is a palpable ripple of achievement when the patient mumbles a few words about his stomach; Dr B nods in satisfaction and pats the man's shoulder, communicating through a form of touch different from that of the medical examination. Is this, I wonder, a rare shared 'existential moment' (Das 2015: 25) that the doctor-patient encounter so often obscures or denies?

¹⁶⁹ See Das on the way in which *takleef* can capture the overlaps between 'the notion of the symptom, the medical complaint, and the idea of discomfort' (2015: 33).

During my months at AIIMS, I also shadowed Dr B on his ward rounds. Patients' attendants were made to leave the wards before the doctor and his entourage arrived; people would often cluster around the entrance, waiting to offer a *namaste* to the doctor, trying to catch his attention for a word about their relative's condition. Dr B's patients were all either pre- or post-operative, and all were extremely ill. They lay on beds whose white sheets, with 'AIIMS' stitched into a red border, were sometimes stained and sometimes had a hole in, supplemented with a blanket or two brought from home. Many patients wore their own loose clothing rather than a hospital gown, and on the cabinet beside the bed might be a packet of milk from the Mother Dairy shop on the hospital compound, or a bottle of Miranda orange, or occasionally a more expensive carton of pomegranate juice. Occasionally a fly traced shapes in the air above the beds, embodied proof of the permeable hospital boundary.

Dr B's manner was generally more brusque on the wards than in the OPD. Patients often struggled to sit up as they saw the doctor approaching, or at least to make some acknowledgement of his approach – folding hands in greeting, or quickly covering the head with a dupatta. Dr B did not always acknowledge the person in the bed, whose flesh yielded beneath his fingers. Patients watched mostly in silence as their bodies were palpated, the viscous contents of tubes extending from their flesh examined, and their charts scrutinized by Dr B and his small flock of senior residents, nurses, and me.

Occasionally he appeared thoughtless. He might talk over the wails of a middle-aged woman distressed by her nausea, leaving her to be soothed by a young nurse who whispered to her and stroked her hair in a gesture more intimate than anything I had yet observed at the hospital, demonstrating both the qualitative division of labour between doctors and nurses and its heavily gendered dimension¹⁷⁰ (Kirkpatrick 1979; Riska & Wegar 1993; Turner 1987: 146–151).¹⁷¹ One young man remained on the ward twenty-one days after his

¹⁷⁰ The tradition of gendered authority was also regularly voiced by patients who addressed female doctors as 'Sir' or 'Doctor Sahab'.

¹⁷¹ Each visit to AIIMS during my fieldwork yielded new potential avenues of research that I have been unable to explore in this thesis. A more thorough investigation of how touch

operation. He wore white cotton pyjamas and from where I stood at the end of his bed I could see the dry scaled skin on the soles of his feet. A senior resident took the man's X-ray films from the bedside cabinet and held them up to the light for the group to see. Dr B pulled up the patient's pyjama top and palpated his abdomen; he asked a question to which the patient shook his head. Then the group moved on, leaving the young man to pull down his top and cover his exposed skin.

But there were other moments when, while never effusive, Dr B seemed to intuit that patting a patient's knee, or lingering to offer a reassuring word, would provide necessary comfort. One morning in the intensive care unit positioned at the end of a ward, I joined Dr B's group beside the bed of a man made prematurely elderly by disease. So emaciated that the contours of his skull appeared sharp beneath a fragile layer of skin, he was agitated, repeatedly tapping the metal bar at the edge of the bed. His lower jaw trembled as he moved it in an attempt to speak, but he made no sound. 'Araam se saans lo' ['relax, breathe gently'] Dr B said, and put out his hand for a stethoscope, which was immediately proffered by two residents. He listened to the man's chest, but the patient was still panicking, shaking his head. Dr B tapped his hand. 'Koi dikkat nahin hai' ['there's nothing to worry about,'] he repeated, and kept his hand still as the man began to calm down, and then gradually began to smile until he appeared almost to be on the brink of laughter.

'The closed world of words'

An elderly man enters Dr L's consulting room alone, which is unusual. We are in the midst of Delhi's annual dengue fever outbreak and I have come to be more grateful for, and less intimidated by, the surgical mask that Dr L insists I breathe through. Having elicited a complaint of breathlessness from the man and read his notes from a previous appointment, Dr L proceeds to discuss the case in English with an intern and a junior resident. The man sits frail and diminished on a stool

functions as care or discipline in different contexts is one example from this passage. A study of nurses and nursing at AIIMS is another theme that deserves its own attention.

in a well-worn cotton shirt and trousers, his eyes flicking anxiously between the three doctors standing above him. They occasionally gesture towards his sickened body as they discuss it in a language he cannot comprehend. Is it worse than he thought? Does he need an operation? Are they discussing his impending death? 'Please explain to him,' Dr L instructs one of the students. As the patient cannot read, his medicines and inhaler type are decided accordingly for ease of use. 'Your prescription for the patient should be very very clear,' Dr L says. But what are the implications for trust here, and for how the role of medicine is understood, when the doctor-patient encounter is conducted at least partly in a language inaccessible by the least powerful party?

On the wards, case discussions take place at bedsides, among professionals who rarely involve patients other than to ask an occasional question. The conversations that take place above a patient's head occur in both Hindi and English, so that the patient might hear talk of her condition in confusing fragments, or miss altogether the news that she is to be allowed home tomorrow. Kalpana Ram (2010) describes a vivid experience of this dynamic from her fieldwork in Tamil Nadu. Invited by a doctor to observe the insertion of a Copper T contraceptive device into a patient, Ram felt acutely uncomfortable about her intimate view of the cervix of the woman undergoing the procedure, whose permission for the anthropologist's observation had not been sought.¹⁷² As she worked, the doctor explained the details of the procedure to Ram in English, intensifying the sense of power imbalance and further emphasising 'the social distance of class' between the doctor and anthropologist, and the patient (206). On a ward in 1960s Punjab, Kirkpatrick writes, 'code-switching' between languages was used as a deliberate device to control the information shared with patients; in the paternalistic language of the time, it was also considered to be a protective mechanism (1979: 97–98).

The learning of medical language is central to the process through which new doctors are created (Foucault 1994a: 114–115; Hafferty 1998). Foucault notes

¹⁷² See chapter 1 for my own experience of ethical ambiguities in this regard at AIIMS.

the perpetuation of a 'medical esotericism' through a language into which a student must be initiated and which is inaccessible to others:

...one now sees the visible only because one knows the language; things are offered to him who has penetrated the closed world of words; and if these words communicate with things, it is because they obey a rule that is intrinsic to their grammar (1994a: 115).

This speech 'can be understood only by those initiated into true speech,' those initiated 'into the truth of things' (ibid.). Foucault goes on to note that this esotericism is different to 'that which made Moliere's doctors speak in Latin'. That, he argues, was simply a deliberate effort to protect professional privilege through a language that the patient could not understand.

At AIIMS, however, both facets of esotericism are at play. For the patient without English, learning what she is to be treated for, and how, demands an act of double translation – a form of 'cognitive comfort' in Kirkpatrick's words (1979: 88) – for which she is entirely dependent on the doctor she sits in front of and whose choice of words she must accept as a translated truth.

Dictating patienthood

...the overall process of medical training helps establish and reinforce a value climate that explicitly identifies matters of rightness and wrongness within the overall culture of medicine. From these perspectives, a significant component of medical training involves the development of a medical morality and supporting rationales within its initiates (Hafferty & Franks 1994: 865, original emphasis).

I witnessed Dr L with a changing cast of students in her OPD. Despite a brusque and occasionally intimidating manner, her efforts to teach a more comprehensive approach to medicine hinged on communication, through which she also transmitted her own expectations of desirable patient behaviour.

*

Sometime after 11am during one of Dr L's OPDs, a woman sits down on the small plastic stool beside the desk. She wears a colourful polyester sari and estimates her age as between fifty-three and fifty-five years old, but to my eyes she appears ten years older. She is accompanied by a younger couple, presumably her daughter and son-in-law, or vice versa. The man sits quietly against the wall, while the woman takes explanatory charge. When the patient herself speaks of her pain and discomfort she looks at me, and I nod in sympathy, knowing that the woman has assumed that I am also a doctor, and wondering if even this small reaction is somehow deceitful. She comes from Jalandar in Punjab, and the family has brought her to AIIMS from Sir Ganga Ram, a private hospital in north Delhi. The younger woman presents Dr L with various pages of test results from various consultations. After conducting her own examination, Dr L decides to admit the patient, even as the patient herself says that she is worried it will prove useless. 'They haven't been able to give her a diagnosis and she needs one, so we give priority to such patients,' Dr L says.

*

During an OPD, a woman in her 50s, with a ready smile, turns her face between Dr L and me as she explains her feelings of weakness ('kamzori lagti hai'). A local doctor has told her she has low blood pressure; in Dr L's opinion, this has exacerbated her symptoms and spurred a search for remedy at AIIMS. 'The standard of general practice is very low,' she says to me, expressing in her own terms the reality in which for many patients from low-income areas, symptoms are conflated with diagnosis by local practitioners. Rather than dismissing the woman's complaint as groundless, in her manner that manages to be both brusque and humane, Dr L says that post-menopausal osteoporosis is a possibility and she orders some blood tests.

Complaints of 'weakness' [*kamzori*] and 'body ache' [*badan dard*] are common in Indian clinics, and are often cited by doctors to illustrate hypochondria, somatization disorders, or the simplicity of illness among the rural poor in

particular. Brijnath (2015) and Cohen (1998) have written about understandings of *kamzori* in old age, while Pereira et al. (2007) have approached it as a somatized feature of depression among low-income women. In 1960s Punjab, Kirkpatrick (1980) encountered *kamzori* among women on a gynaecological ward who associated it with menstruation and multiple childbirths.

Veena Das has written about the treatment of symptoms rather than the pursuit of diagnosis by many practitioners in low-income neighbourhoods, which results in an often chronic condition being understood as an intermittent series of acute episodes (2015: 20). She illustrates this with the example of a young woman who was told that she had 'low BP' without the practitioner taking her blood pressure. In this way, she argues, such categories are 'neither "folk" nor "expert"' – they express linkages to the tensions of difficult living conditions and also carry 'the trace of the clinical encounters typical of low-income neighbourhoods and their particular ecology of care' (ibid.: 44).

While Dr L was frequently frustrated with what might have been unnecessary visits to her OPD, I did not see her refuse anyone attention, even if she didn't always offer treatment. During one OPD, a man in his 40s sat in front of Dr L wearing a mint green knitted tank top and a gentle smile. He asked her to check him over because he had a cough. Dr L listened to his chest then gently chastized him for coming in. He had been coming to her OPD for the last fifteen years, she told me, and she considered it a case of 'somatization disorder' stemming from a childhood history of TB. Perhaps he felt a sense of safety in the medical environment that was denied him in wider society, Dr L mused.

The tests ordered by Dr L in the second vignette above were conducted by the AIIMS laboratory at no expense to the patient. The practice of ordering excessive tests for financial gain through a nexus of doctors and private laboratories has become a key trope in the discourse of corruption in Indian healthcare – a discourse from which AIIMS is not exempt (Rajshekar 2015). In the case of the

patient above, and many others at AIIMS, however, the provision of free tests can arguably be understood as an act of health justice.

The access to functional on-site laboratories is a reminder of the resources AIIMS has at its disposal. It also has consequences for student attitudes towards these normalized resources. On one occasion Dr L chastized a junior resident for filling in the tests form incorrectly. Rather than ticking the specific tests required, the student had drawn a large bracket encompassing all of them. Dr L berated him for both the generalization and the unnecessary load such a demand would place on the lab staff. I watched, embarrassed for the sheepish student, as Dr L crumpled up the form and reached for a fresh one. ‘I’ll do it myself,’ she said. Communication in the clinic is not confined to the patient-doctor relationship, but is also central to impressing upon students what is expected of them as AIIMS-trained clinicians.

Dr L impressed on students the importance of thinking through a case meticulously and of eliciting diverse information to contribute to a differential diagnosis. Questions often needed framing in language appropriate to the existential reality of the patient ¹⁷³, and in this sense the doctor tried to enter into the patient’s lifeworld. In one instance, Dr L criticized a student for recording a young male patient’s place of work simply as ‘Mother Dairy’, a state-run dairy company. The man complained of breathlessness (as did so many patients in heavily polluted Delhi); recording only that he worked at Mother Dairy gave no information about the job profile and tasks involved – was it a sedentary position, or did it demand hours of heavy lifting? Did time and posture have any bearing on the man’s difficulty breathing? Such symptoms were often described as feeling worse at night, Dr L explained, but in some cases that could be explained by a heightened awareness of discomfort during quieter periods, or a more audible rasping of the breath. When the Junior Resident had

¹⁷³ I hesitate to refer to this as an act of eliciting an explanatory model (Kleinman 1988) because its intention was not to understand a patient’s subjective illness experience, or to acknowledge the power differential between patient and doctor, but to grasp the patient’s material context in order to establish a more informed path to an accurate diagnosis. See Das (2015: 27–29) and Lazarus (1988) for a summary of the theoretical responses to the rise of explanatory models in the 1980s. Also Kuipers (1989) for a survey of how linguistic anthropology began to tackle medical discourse, and Wilce (2009) for a rich contemporary account.

asked whether the patient experienced wheezing, he had said no. But when Dr L enquired whether he experienced ‘noisy breathing’ [‘saans lene mein avaaaz aati hai?’], he nodded without hesitation.

This orientation towards patients expressed recognition of the unreliable and often punitive healthcare landscape beyond AIIMS. During an OPD one morning, a student instructed a frail, elderly man to attend a local clinic twice a day to have his blood pressure and blood sugar checked. Dr L overheard and intervened, explaining that a clinic would ‘fleece him for checking twice a day’. She conveyed other lessons to students that alluded to the poverty of patients; this regularly included reassuring patients that certain powdered medicines could be consumed with water and did not require the purchase of milk.

At other times, however, an impression of empathy was confused by Dr L’s impatience. Patients were regularly told that they were wrong. Their answers to her questions were wrong, their understandings of their bodies were wrong, their lifestyles were wrong. The ‘patient labour’ discussed above does not preclude the criticism and correction of these same individuals. Rather, it forms part of the same educational project, informing students not only of appropriate diagnoses and remedies but also of the shortcomings of patients’ ways of being, and – on occasion – of the conditions through which they live.

It is February and already hot. The fan is on a month too early. A glass paperweight stops papers fluttering from the desk to the floor. I remark that the pile of patient parchas in front of Dr L is smaller than usual. She replies that the hospital feels relatively quiet and wonders if people are staying away because of the publicity around Delhi’s swine flu outbreak. A middle-aged woman is led into the consulting room by her husband and son. They are concerned about a tremor in her hands. Dr L teaches her students to involve the patient’s attendants in a conversation if it might be helpful to diagnosis. Accordingly, she asks the men to describe what they have observed in the patient and they both respond with ‘kamzori’ [‘weakness’]. Dr L shakes her head and pronounces that this is a subjective feeling, not an objective judgement. She proceeds to voice her suspicion of Parkinson’s disease. Cowed, the family sit in silence.

*

A middle-aged man enters the small consultation room with his son; he is bloated and a large vein throbs visibly in his neck. On sight of him Dr L immediately begins shouting that she will not take responsibility for him if he refuses to take responsibility for himself. The son's sheepish smile quickly fades beneath the doctor's barrage of words. Dr L turns to me and explains that the man had been admitted to the hospital last year with congestive heart failure (CHF), and was decongested and discharged with a management programme. He has not returned to AIIMS until now, however, when he is once again in a state of advanced CHF, with a pulse of 48. Dr L immediately admits him. When he and his son have left the room she tells me that she knows that many AIIMS patients are 'so preoccupied with making a living' that they only return when they are very ill and it seems absolutely necessary.¹⁷⁴ 'I understand it from their point of view, but sometimes as doctors we feel so helpless.' Her anger appears, on this occasion, to be a manifestation of distress.

*

It is the same already-hot day in February; a woman and her son come to the OPD. Speaking on his mother's behalf, the son explains that they have been sent from both gastroenterology and endocrinology, following a series of investigations into his mother's 'swelling'. He presents Dr L with a sheaf of test results which she leafs through, finally looking up to declare that there is no apparent illness and that the swelling is most likely the result of sedentariness. 'It is not money that will buy health,' she suddenly says, 'it is lifestyles.' She looks at the slightly bewildered mother and son. 'Dawai [medicine] is not the solution for everything.'

¹⁷⁴ See Das (2015: 41) for a patient's confirmation of this.

This assertion, and the accompanying command to ‘take responsibility’, seemed an almost wilful denial of patients’ lives beyond the hospital, at odds with the impression Dr L had given on other occasions. Medical technologies have never been so central to perceptions of health and healing in India given the unprecedented exposure (if not access) to these purported solutions (Das 2015; Ecks 2005; Van Hollen 2003). DelVecchio Good’s ‘biotechnical embrace’ (2001), or what Amrith describes as the association of ‘health with *things*’ (2006: 130–133, original emphasis), is as encompassing of patients as it is of medical students. An AIIMS doctor’s denial of this order of things challenges a patient’s informed understanding that medical technologies hold the key to a modern state of health.

Dr L combined her identification of an epidemiological trend (an increase in symptoms associated with inactivity), with a discourse of individual responsibility, into instructions to patients that took little account of local context. ‘Go for a walk’ she would say. While the poorest patients are, almost by definition, unlikely to suffer from complaints related to voluntary inactivity, it remains the case that walking as a form of exercise (Dr L generally recommended five kilometres a day) demands infrastructure, footwear, time, and freedom of movement, all of which may be precluded by the socioeconomic conditions of a patient’s life.

On another occasion, Dr L belittled a father and son for not ‘taking responsibility’ by failing to ask their previous doctor for the boy’s most recent chest X-ray. Here we encounter institutional insulation at its most myopic, where it refuses any recognition of the intimidating power relations that inhibit patients from taking such actions. As Rapp (1988) and Van Hollen (2003) have pointed out, it is often the case that ‘the symbolic content of health-related messages is less important than the social hierarchies such messages reassert’ (in Pinto 2008: 139); at AIIMS, such communication not only reasserts hierarchies in the minds of patients, but also acts as a pedagogical performance, impressing upon students the relational dynamic in the clinic to be reproduced through mimesis.

Taylor and Wendland argue that ‘the curricula of medicine – formal, informal, and hidden – rigorously schools practitioners in individualism as a habit of thought and practice, in ways that discourage, or even disable, social and cultural analysis’ (2014: 52). Among urban consumers in India, a discourse of responsibility and the crafting of a new form of citizen-patienthood is well underway,¹⁷⁵ in a largely privatized landscape increasingly augmented by (literal) technologies of the self (Foucault 1988; Das 2015; Ecks 2004), including apps through which a patient can monitor herself and consume tailored healthcare on demand, and air purifiers which insulate privileged homes from the indiscriminate threat of particulate matter.

The demographic most able to consume this new form of health management, however, is rarely represented at AIIMS. For many of these patients, personal responsibility for health and care has long been the default mode of being, in the absence of reliable state provision (Pinto 2004, 2008). As I suggested above, a journey to AIIMS can be understood as an expression of biological citizenship, or ‘visibility work’ (Street 2014: 13), through which a patient demands that the state take responsibility for the provision of care. It is from this perspective that a lecture on personal responsibility by an AIIMS doctor might seem perplexing to a patient, while also conditioning a student to understand affliction and patienthood as determinedly individualized conditions.

Despite her demands that patients be more autonomous, Dr L could also be affronted by assertiveness. During one OPD, a young woman around twenty-five years old entered the consulting room accompanied by her sister. Employed as an ‘RJ’ (radio jockey), the patient was confident and self-possessed, she spoke firmly and fluently in English, articulating her understanding that a malign tumour was growing in her brain. She continued speaking as Dr L interrupted her, but gave up as Dr L persisted. Dr L asked about a particular test while looking down at a sheet of paper from the patient’s file. The sister responded politely that the test had been done. Dr L snapped back, ‘Obviously she’s had it

¹⁷⁵ See Rose (2007) on this phenomenon in the Global North.

done if it's here in front of me.' In such instances of transparent rudeness rather than a brusque efficiency, I was unsure what was going on. Was a patient's assertion, or intellectual command over his or her own condition, received as a threat to medical authority? Did this expose a limit to Dr L's repeated demand that patients take responsibility for their own health?

Ram suggests that, 'in the spaces of clinics and hospitals, didacticism is, if anything, further accentuated as a mode of authority' (2010: 206; also Pinto 2004). These moments when Dr L firmly inhabited the traditional didactic mode of the doctor, seemed at odds with her efforts on other occasions to acknowledge the realities that informed and constrained patient behaviour, and to adapt her own accordingly.

'We're not considering the person as a person'

In March 2015, in conjunction with the Centre for Medical Education and Technology (CMET), the Department of Psychiatry organized a communication skills workshop. The workshop was voluntary; while the organizers had expected around twenty-five to thirty students, they began with six and ended with thirteen. Two junior residents in attendance told me that even if people wanted to attend they would find it difficult given the various academic and clinical demands on their time. A resident I recognised from Dr L's OPD confirmed the need for faculty support – Dr L explicitly encouraged her students to attend such workshops, he said.

The workshop began with an introduction to the importance of communication in medical practice. When students were asked to imagine themselves as patients and to articulate what they expected of a doctor, they agreed that a doctor should: listen carefully, explain the method of investigation and diagnosis, give treatment options and explain their pros and cons. Throughout the afternoon, those present demonstrated a capacity, and often an enthusiasm, for self-critique and discussion of behaviours and protocols that at times felt at odds with the institutional context in which we sat.

A young member of the psychiatry faculty spoke with conviction to the small class as he explained that patients were viewed as collections of symptoms rather than as human beings. ‘We’re not considering the person as a person,’ he said. Doctors failed to listen properly and were too focused on the symptom-diagnosis-treatment trajectory to look up and engage with the human being in front of them. He urged empathic listening, and a vigilant awareness of the trials the patient has already gone through before he reaches the consulting room: he has come on a train from Bihar to queue at AIIMS from 3am, he may not have eaten, and he is ill. ‘He has so much to say, for heaven’s sake give him half a minute to express himself.’

A later session guided students through an ideal doctor-patient interview. Language was central, the instructor explained. ‘Why’ questions often sounded accusatory and threatening (and rarely have straightforward answers). Students should impart reassurance by telling the patient that they understand their condition. Actions and examinations should be explained: a doctor should invite a patient to the examination table by explaining that she would like to examine her, rather than using the standard command, ‘*let jao*’ [‘lie down’] that echoed through the hospital corridors. A consultation should end with the doctor asking if the patient has any questions, the instructor said. I could not recall having observed this in the many OPDs I had observed by this point. Rather, consultations tended to end with a rhetorical ‘*theek hai?* [all right?]

and a dismissal often signalled by the doctor’s selection of the next *parcha* from the pile, or by telling an assistant to call the next patient. During one of Dr B’s busier OPDs, when twelve people occupied the roughly ten-foot square consultation room, an elderly man sat on a stool and watched as the senior resident who had been speaking to him left the room. He remained sitting patiently until the doctor returned, looked at him, and asked why he was still there.

Preparing for a doctor-patient role-play, when one student said he wasn’t sure how he should address patients, he was told to always use *aap* as the default mode of address and to employ ‘culturally appropriate terms’ that took into account age, gender, and the relationships between people. This led to an exercise in which students had to grapple with a tension between ‘culture’ and

patient agency. Two groups were asked whether a doctor should request the presence of a female patient's husband before breaking bad news about her condition. The scenario reminded me of several occasions in Dr B's OPD (which saw a significant number of patients at a terminal stage of illness), when I was briefly confused about who the patient was, as information was conveyed to the husband of a female patient, or an elderly parent was sent out of the room before the gravity of his condition was explained to his children.¹⁷⁶ Responding to the scenario, one group said that the husband should be called, reflecting normative values around kinship and patriarchy that they felt should be respected. Whereas the spokesperson for the other group disagreed and cited bioethical literature to claim that the woman's autonomy must be respected.

The different answers of the two groups illustrate two different ways in which AIIMS is permeated by prevailing currents. In the first case, the group that decides to wait for the husband presents a clear example of how doctors' behaviour is influenced by pervasive social norms. In the second case, what may at first appear to be an instance of insulation, becomes on second glance an example of adherence to a narrative of 'culture-free medicine' (Taylor & Wendland 2014; also see Lock & Gordon 1988) at AIIMS, that seeks instead to privilege a supra-national, determinedly modern, discourse of bioethics, with echoes of the discourse that accompanied the Institute's foundation moment.

I left the workshop enthused about the possibilities it opened up for AIIMS as a space in which the determinants of power that leak into the clinic through communication were recognised and challenged. While time constraints were acknowledged, a discourse of pragmatism was replaced by one of empathy. On further reflection, however, it seemed that what was being taught was communication as another medical instrument. While empathy for the human other was stressed, the structures of difference that influence communication and the mutual perceptions of patients and doctors at AIIMS were not on the agenda.

¹⁷⁶ See Mukherjee (2013), a US-trained physician, for an account of his shock at the lack of patient privacy at AIIMS.

Even acknowledging the workshop organizers' constructive intentions, it was only conducted for thirteen students. This is not how students learn to communicate with patients at AIIMS, nor how they reach conclusions about patient behaviour and exemplary medical practice. They learn through osmosis, by observing faculty members, of whom some place more importance on the communicative relationship than others, but none have the time to discuss its implications in depth with students. Perhaps the greatest shortcoming of this behavioural transmission is the denial of opportunities for students to discuss their pre-existing ideas about and orientations towards the people of low socioeconomic means who make up the vast majority of AIIMS patients, and whose bioavailability, as we have seen students acknowledge, directly contributes to the value of an AIIMS education.

*

If surrounded by a medical culture that discourages certain feelings, introspection, or personal reflection, and buffeted by a basic science curriculum that emphasizes rote memorization, medical students may come to embrace...a reflexive myopia quite early in the training process. (Hafferty & Franks 1994: 866)

My intention in this chapter has not been to prove the inconsistencies of particular doctors operating under pressure, but rather to illuminate the vagaries of a hidden communicative curriculum and to suggest that relying on osmosis and mimesis as the methods through which students learn to relate to and communicate with patients invites an inconsistent impression of the behaviour they believe they and patients should emulate. The variation in communication methods, the swiftness with which impatience is blamed on time pressures, and the efforts of a few to engender better communicative practice through non-compulsory instruction – each of these dimensions presents communication as another lens through which to understand how AIIMS reflects social norms that are often as entrenched within as without the clinic.

There is, however, a deeper question raised by this chapter, about how communication itself is understood primarily as a tool to express empathy and

courtesy towards a human being who is differentiated not only by virtue of being a patient, but often at AIIMS also by poverty and limited literacy. ‘Communication skills’ remain reduced to variations on the theme of etiquette, rather than stimulating an interrogation of the ways in which linguistic interactions ‘both shape and reflect power relations, cultural identities, and social norms’ (Ahearn 2012: 291; Bourdieu 1991); any deeper sociological content remains implicit, including the value that students told me the large number of patients adds to their education. Taylor and Wendland (2014) note that the sociological origins and potential of the concept of the hidden curriculum, while well understood by Hafferty (1998), have tended to be ignored within the academic literature on medical education, which emphasizes the primacy of individual behaviour modification. Noting a debt to Marx and Gramsci (with regard to whom they propose relabeling the ‘hidden’ curriculum as ‘hegemonic’), Taylor and Wendland (2014) advocate a more ambitious, collective response to structures rendered invisible:

Institutions of education systematically teach people to *unsee* their social world in ways that contribute to the maintenance of existing relations of class and power – but education *could* teach people to *see* their world clearly, and support their capacity to transform it (51, original emphasis).

How might an open interrogation of the doctor-patient relationship influence the behaviour of our neophytes? An effort to extricate the social world from the hidden curriculum and make it visible would demand a curriculum that ventured beyond medical sciences into the social sciences, beyond mugging up into discussion, and the training of teachers committed to providing the intellectual challenge and engagement that several students noted was lacking at AIIMS. How might the impression of this type of *gnosis* (Turner 1967: 102) inform the ways in which our ‘evolving subjects’ go on to ‘transform health, power, and other aspects of social life’ (Holmes et al. 2011: 105; Wilce 2009)?

In the next chapter, I remain focused on these questions by returning to the experiences students *do* have at AIIMS, and looking at how they inform

future aspirations, as our students begin to contemplate life beyond the gates as the country's 'best' medical graduates.

CHAPTER 7.

‘AIIMS KILLED THE GP’: ACHIEVEMENT, ASPIRATION, AND PRECLUDED FUTURES

In this final ethnographic chapter, I focus on what our students plan to do next, as the end of the MBBS approaches. In Turner’s (1967) sense, the students are on the brink of emerging from the liminal stage of their initiation into medicine and being reincorporated into society as doctors. The majority of this chapter is concerned with understanding how students’ perceptions of possible futures are shot through with discursive threads about achievement and reputation, the state, money, and modernity. These various threads produce a value hierarchy of biomedical practice in contemporary India, within which inheres a conventional wisdom about the devaluation of the MBBS degree, and the logical pursuit of a career in urban, super-specialized medicine. Throughout the first half of this discussion I have placed a series of ethnographic vignettes intended to illustrate the fragmentary consequences of a reliance upon specialist treatment by patients in the absence of an integrated system of care.

I suggest that whether a student aspires to a career in super-specialized urban medicine, public health, or the civil service, the choice is inextricable from the status bestowed upon AIIMS students at the moment of admission. The social life of this achievement (Long & Moore 2013), combined with the influence of norms around gender, class, and kinship, produces expectations of the future and an individual’s place within it, offering different impressions of what it means to be a graduate of India’s most prestigious medical college. I conclude the chapter with three stories of ‘precluded futures’, which examine how simple narratives of ambition and achievement may obscure complex dynamics informing students’ decision-making, and offer another challenge to the discourse of freedom that we encountered in chapter 4.

Finally, I suggest that this final chapter further illuminates my argument that AIIMS is complicit in the sociomedical landscape beyond its gates, provoking questions about the position of the country’s most respected medical college as both training institution and role model.

The new conventional wisdom

Because familiarity is such an important test of acceptability, the acceptable ideas have great stability. They are highly predictable. It will be convenient to have a name for the ideas which are esteemed at any time for their acceptability, and it should be a term that emphasizes this predictability. I shall refer to those ideas henceforth as the conventional wisdom. – J.K. Galbraith, The Affluent Society (1998[1958]: 7–8)

Of the 27 MBBS students with whom I conducted at least one in-depth interview, 21 intended to pursue a medical career. Of these, all intended to study for a postgraduate (PG) qualification immediately after their MBBS. This intention contained a logic considered irrefutable, that to practise medicine with only an MBBS qualification was, if not an outright impossibility, then certainly an act of professional self-harm.

MBBS has now become just like a preliminary examination, it's a 'pre', so the actual doctor should at least do PG, otherwise you are not a doctor.
– Nikhil

MBBS [alone] is considered nothing here; you are not considered a good doctor if you have only MBBS degree. You are supposed to do PG and then after that super-specialization. Even if you have done a postgraduation degree here, you are not considered that good a doctor if you don't have a super-specialization degree. I guess that's the case all over now, not only in AIIMS. Everywhere people are encouraged to get more degrees. I don't like that trend basically. – Neha

In India if you hold just an MBBS degree it makes no sense. I mean you stand nowhere. Because no patient would want to go to a doctor who is not specialized. So everybody who wants to stay in medicine, everybody wants do a specialization. No one can survive without a specialization here, with just an MBBS. – Dilip

Dilip's statement reveals the polyvalence of 'survival' across contexts; in his case, a perception of survival is influenced by his socioeconomic milieu and his identity as an AIIMSonian. In a literal sense, the claim that specialization is key to survival is contradicted by moving around any but the most upmarket urban neighbourhood, and even more so beyond the city. The local MBBS doctor, for

whom medical practice is a *means* of survival, remains a familiar figure in lower income locales, and, I would suggest, deserves more attention from anthropologists as a figure who sits between the informal practitioner (Das 2016; Pinto 2004) and the specialist. From a public health perspective, MBBS doctors have tended to fare poorly in studies of their capacities for accurate diagnosis and effective treatment (Das & Hammer 2004). This lends credence less to the perception that an MBBS doctor cannot survive at all, than to that which assumes anyone practising without a specialization is incapable of winning a postgraduate seat.

Of the 21 students intending to study for a postgraduate qualification, 14 planned to study a super-specialization, four weren't sure, and three intended to practise with only a PG. This seemed to reflect the sense that Krish and Rahul articulated of being on the cusp of a transition to the necessity of super-specialization; within a few years Krish thought medical students would have no choice at all:

Twenty-thirty years back just MBBS doctors were doing all these things, no PG specialization anything. But now PG is everything, without PG we can't do anything. It's becoming a trend that super-specialty is everything, without super-specialty we can't do anything. At present if I am postgraduating I will be just OK in medicine, but in my time in five-six years, I will be doing super-specialization.¹⁷⁷

Krish's 'twenty-thirty' year span encompasses the flourishing of India's corporate hospitals, which have created a market that not only purports to sell a 'five star' service (Lefebvre 2008) to patients, but which also influences the value of particular forms of medical practice in the eyes of both those patients, and of aspiring doctors.

Nowadays all hospitals have become super-specialty hospitals, so they will need only one physician or something...and the work of the physician would be just to refer to other super-specialty, not...the physician will get

¹⁷⁷ This shift is illustrated by Madan, who shows that in the 1970s it was not assumed that all MBBS graduates would proceed directly for postgraduate training (1980: 63).

only normal cases, no challenging cases, no system-wise cases, just infectious diseases or something like that. If you get any heart case, or brain case, or nephro case, you have to refer it. And he won't be getting that chance to treat a patient. But if you are super-specializing in something, you will be getting a particular group of patients...so I think after ten more years, the job of a physician will be just referring only.¹⁷⁸

– Agam

Compounding this sense of the necessity of specialization, was the fact that many students considered themselves insufficiently equipped to practise medicine upon completion of the MBBS. We saw in the previous chapter the way in which the intern year is sacrificed to studying for the PG entrance exam:

I'll tell you a scenario: if I am in AIIMS doing MBBS, my first goal is to get into the postgraduation. And when I am in postgraduation, my first goal would be to super-specialize. During that process, that patient interaction, that new learning from the patient, gets decreased. Because what an individual will tell himself [is], why would I waste my time; I can go to my room, read books, solve the MCQs and crack the super-specialization test – I can be a super-specialist. – Deepak

This begins to appear self-fulfilling as MBBS graduates maintain that they have no chance of a viable career, in part because they don't feel qualified to practise, which is itself in part because the time of sustained clinical exposure is dedicated to studying for the postgraduate entrance exam. This argument does not hold in all circumstances, however, as we will see below when students speak of wasting their skills in rural healthcare settings.

The fragmented body (1)

The journeys patients make through a landscape of fragmented care are made visible through the documents that they are obliged to carry with them from appointment to appointment.¹⁷⁹ For all the faith invested in enhanced medical

¹⁷⁸ There is also an important legal impediment here, which bars non-specialists from undertaking specific medical procedures. In renowned heart surgeon Devi Shetty's example (2015), if he were to perform a caesarean section, he could lose his licence.

¹⁷⁹ As I write, AIIMS is undergoing a systems upgrade that will include the digitization of medical records. It will be interesting to observe in coming years how this may alter the patient

technologies, it often seems that it is paper in which the real power lies (Gupta 2012; Hull 2012). Paper expresses a search for remedy through different letterheads, watermarks, the names of hospitals and doctors and laboratories around the country. The responsibility of patients for the pieces of paper on which sometimes illegible scribbles compress medical histories is expressed through care. An elderly couple produce a parcha that has been laminated for protection. Another couple's card is worn soft by touch and has yellowing tape staving off complete disintegration. In Dr A's OPD, a patient presents test results on a flimsy sheet of paper too damaged to be read with confidence; the process has to begin again. Documents are often kept in plastic bags with their origin stories in a clothes shop in Faridabad, or a wholesaler's in Bharatpur, and in the plastic wallets stamped with monochrome flowers and the legend 'My Clear Bag', sold by a boy at the AIIMS gates in every weather. This legacy of protecting one's own medical records is visible during one of my ward visits, when a patient's husband pulls an envelope of CT films from beneath the mattress.

A middle-aged woman and her husband enter the consultation room. The woman has been diagnosed with depression and multiple symptoms, including severe back pain. Her husband takes file after file from a plastic bag – a variety of test reports, and records from different hospitals are spread all over the desk representing a chaotic medical history. New test forms get mixed up with old reports as Dr P leafs through the collection. He reads the last entry on each record, and it seems that only by combing the existing information meticulously is he able to find that the method of treatment he intends has already been prescribed by a doctor in another department. The husband seems to already be aware of this. He asks Dr P to give his wife an injection. Dr P continues looking through the papers and sees that a result that shows compression of the woman's spine. He sends them to the neurosurgery OPD. Dr P describes this as one of a proliferation of cases of 'reverse referral', whereby a patient goes directly to multiple specialists, before resorting to the medicine OPD to seek clarification about the parallel courses of treatment, and even diagnoses, that she has been offered.

'Patient demand'

An increase in patient demand was central to student narratives about the growth of super-specialization. I was frequently told that the ever-expanding private healthcare market, coupled with the internet,¹⁸⁰ had largely convinced patients of the expediency of consulting a specialist directly, leaving medical students little choice other than to pursue that career path. 'Everyone wants to

experience of the hospital, and what its implications are for patient surveillance and the extension of the clinical gaze.

¹⁸⁰ The role of the internet, and particularly the plethora of new apps available for the self-monitoring of one's health, suggests a rich avenue of potential future research into technology and the individualization of responsibility for health and care in India.

come to a super-specialist,' a senior surgical resident told me. 'If they have a headache, yes, let's consult a neurologist. For chest pain you consult a cardiologist.' Krish explained to me how this manifested in his home state of Kerala:

What happens is that...if I get an MBBS degree from here and go to Kerala and if I sit in a clinic, patients won't come to me. That is the truth. We can't run a clinic with a mere MBBS degree. If I have a chest pain, if I am breathless, if I am having some breathing difficulty, what happens in Kerala is they will go directly to a chest specialist, who has not even MD medicine, rather DM in cardiopulmonology. They will go directly to the one with a DM. Even if you are a paediatrician, still you have to specialize in something, like paediatric cardiology. Earlier surgeons used to do all the surgeries. Nowadays the paediatric surgeons only do the surgeries of children.

Much as the advertising of medical technologies is visible in low-income neighbourhoods (Das 2015: 21, 220–221), so signs declaring the doctor within to be a cardiologist or dermatologist or fertility specialist have also proliferated. These small concerns exist in the vast shadow of the super-speciality corporate hospitals that have come to define the urban tertiary care landscape (see chapter 1). It does not follow, however, that the direct pursuit of specialist care is universal. When Das asked residents of the low-income Delhi neighbourhoods where she worked why they went to see specialist doctors, she writes that:

It then emerged that there were 'normal' illnesses for which such remedies as indicated by the idea of the necessary harmony between doctors and patients worked, and then there were critical turning points in an illness – when, for instance, it became incomprehensible to their normal practitioners and then the 'big' doctors had to be accessed. (2015: 217–218)

For the patients that Das cites, direct resort to specialist doctors is precluded by both financial restraints and any assumed correlation between a headache and the necessity of consulting a neurologist. When explaining that no patient would choose to visit an MBBS doctor if the option of seeing a specialist directly was available, students spoke to the socioeconomic milieu from which they came, and in which they intended to practise. They purported, however, to

speak for all but the very poorest, and in doing so reflected Leela Fernandes's argument that 'mainstream national political discourses...increasingly portray urban middle class consumers as the representative citizens of liberalizing India' (2006: xv; Lukose 2009). It is of these citizens, and the way in which the contemporary discourse of Indian health increasingly frames them, that Baudrillard could have been writing in 1970, when he reflected that: 'Health today is less of a biological imperative linked to survival and more of a social imperative linked to status. It is less of a fundamental value and more of an "assertion"' (1998: 218).

I have suggested throughout this thesis that AIIMS is both insulated from and permeated by sociomedical realities beyond its gates. In this case, both dimensions interact to produce my third contention, that the Institute is also *complicit* in that broader landscape. The observation that Indian patients who can afford it are increasingly going directly to specialists may be valid¹⁸¹, but AIIMS cannot confirm this hypothesis because all its patients are by definition seen by a specialist, even if very many of them present themselves at the hospital unsure of which department they need to visit, having simply been directed to 'go to AIIMS'. Thus, the narrative of patient demand is fuelled within students and doctors' own socioeconomic milieu amid the increasing visibility of specialist services, and further consolidated by the confirmation bias lent by experience at AIIMS. What results from this is the new conventional wisdom that *all* patients have lost respect for the generalist, for reasons other than absent or inadequate care, imbricated in the meanings of social mobility and medical modernity, with the consequent hyper-valuation of a career as a super-specialist.

In his work towards an anthropological theory of value, David Graeber describes the challenge of reconciling social structure and individual desire (2001: 76). The idea that value emerges through *action* points in this direction, by both understanding value as 'the way people represent the importance of their own actions to themselves,' *and* recognizing that 'it can only happen through that

¹⁸¹ This development is in keeping with the historical trend in the US, another country with little traditional state involvement in healthcare provision (Weisz 2008).

importance being recognized by someone else' (ibid.; Munn 1986; Otto & Willerslev 2013).

...one might go so far as to say that while from an analytical perspective "society" is a notoriously fluid, open-ended set of processes, from the perspective of the actors, it is much more easily defined: "society" simply consists of that potential audience, of everyone whose opinion of you matters in some way, as opposed to those...whose opinion of you, you would never think about at all. But...value is not *created* in that public recognition. Rather, what is being recognized is something that was, in a sense, already there (Graeber 2001: 76–77; also in Graeber 2013: 226).

Value, then, becomes less exclusively about what someone *wants*; the concept of desire expands to take into account feelings of obligation and perceptions of legitimacy. As Graeber puts it, drawing on the mid-twentieth century anthropologist Clyde Kluckhohn (1951):

[Values] are the criteria by which people judge which desires they consider legitimate and worthwhile and which they do not. Values, then, are ideas if not necessarily about the meaning of life, then at least about what one could justifiably want from it. (Graeber 2001: 3)

In a simple sense, this formulation speaks to why Dilip, above, can speak about his career prospects in terms of 'survival' – to survive in the milieu in and through which he and others consider the value of his actions is to *thrive* in a manner inaccessible by a neighbourhood MBBS doctor. We can also connect these thoughts to Long and Moore's call to ground an understanding of achievement 'in a theory of human sociality' (2013: 13). Moore notes elsewhere that the self-other relations that achievement may allow a subject to 'cultivate and transform,' are 'set up in fantasy, based on a series of identifications and their circulations ... [and] shot through with social imaginaries and relays of power' (2011: 76).

Student understandings of patients' perceptions of medical value, then, informed their own views, their aspirations and decision-making. It should also be noted that some students were explicitly motivated to pursue super-specialization by an interest in a specific field. Vipul told me that the more he

learned about a subject the more interesting it became, which motivated him to pursue particular fellowships during his MBBS studies, and encouraged him to specialize. Balraj had developed an interest in ‘the brain and spinal cord’ at school, and was more determined than ever to become a neurosurgeon. Including a specific fellowship at Johns Hopkins, he knew that he would spend ten years post-MBBS training to reach his goal. The ambition to become a super-specialist, suggests that for a student like Balraj, the process of initiation continues, a sense of liminality stretching out before him to become an almost permanent state of being (Szakolczai 2015).

The personal logic of pursuing a super-specialized career did not necessarily preclude critical thinking about the implications of the trend for a population that suffered so much for want of accessible and competent basic care. A sense of ambivalence was common:

From the perspective of public health, it’s not a good thing. Because the patient has...a person specializing in a super-specialty like neurology¹⁸² he will have to refer the patient for almost any other thing besides neurology. So from public health perspective it’s not good. But for patients who have a really bad intractable disease, for them, super-specialty is good. So it’s like we need to balance these two things. – Vipul

George Weisz (2008) offers an elegant comparative overview of the history of specialization in Britain, France, Germany and the United States, in which concerns about the potential domination of specialization over general practice are common. Work on specialization in low and middle-income countries remains sparse, although see the work of Ecks (2010) with Indian gastroenterologists for a valuable exception. While interest is growing in this area in India, the focus appears to be on the development of particular

¹⁸² While it is not my concern to interrogate the characteristics of particular specialties and the determinants of specific student choices, this is an important area of research which, while relatively well-established in the Global North (Album & Westin 2008; Mutha et al. 1997), has yet to fully materialize in other contexts. To my knowledge, such work on the Indian context is underway at two institutions, with great potential for illuminating how factors such as gender influence choice of medical speciality. By way of brief example from my own work, Anjali was told by an uncle and former surgeon, that there are certain ‘things that girls can never do [including surgery] because they have to raise kids.’

specialities, rather than the nature of specialization itself and its influence over the landscape of illness and medical care.

The dearth of seats for postgraduate medical training – approximately 14,000 for the country's 50,000 annual MBBS graduates – was often cited as a natural counter to the specialization trend; a logistical problem that also acted as a check on the number of specializing graduates (although it was not considered a genuine threat to an AIIMSonian). This logical narrative stumbles, however, at the value question. Those who fail to win a postgraduate seat do not necessarily accept the outcome and enter general practice. A large number of graduates spend several years sitting and re-sitting postgraduate entrance exams in an effort to join a specialist branch. Dr Raman Kumar of the Indian Academy of Family Physicians estimates in the absence of recorded data that India currently has 300,000 MBBS graduates who are not in full-time work.¹⁸³ It is also common for students unhappy with their branch to re-sit exams in an effort to win a seat in their preferred specialization. This regularly occurs in the Centre for Community Medicine at AIIMS, which is used as a stopgap by junior residents seeking a different branch (see below). As Dr B said when we discussed this point, 'not just AIIMS graduates, *any* graduate – no one wants to be a general physician.'

Here again we encounter the impact of AIIMS on the broader medical landscape. AIIMS has largely failed in its founding mission to systematically produce teaching clinicians for the country, not least due to the lack of supporting infrastructure. It is, however, pre-eminent in the imagination of aspiring doctors, and is thus partly responsible for producing an idea of medical value not only in the minds of its graduates, but in the minds of those who would seek to emulate the AIIMSonians they could not become for want of a higher rank. In this sense, the 'social knowledge' (Long & Moore 2013: 22), and the value, both produced and confirmed by the act of entering and graduating from AIIMS, ripples far beyond the gates of the institution to impact aspiring

¹⁸³ Personal communication, 9/3/16.

doctors across the country, who look to AIIMSonians to demonstrate what it means to be the best.

The fragmented body (2)

March 2015. It is hot, and the fan is working hard; notebooks, pens, a stethoscope, all act as paperweights. A very large man wearing a beautiful embroidered green velvet hat shuffles into the room and dwarfs the plastic chair he is guided into. He is aided by another man who I initially imagine to be his brother, but he identifies himself as a colleague. When they have left, Dr L says it is likely that the man is a paid attendant. The patient has apparent neurological problems beyond a lack of physical coordination: his speech is slow and slightly slurred and he seems not to comprehend Dr L's questions, even as she speaks deliberately slowly. The attendant proffers a folder of hole-punched, carefully bound papers from various hospitals, including Apollo. He speaks a determined, deferential English to Dr L, and tries to offer clarification even though he clearly has little familiarity with the man's medical history. The patient's wife has cancer, the man says, and his children have 'problems'. The paper trail suggests diabetes, but Dr L can't find a prescription, and neither the patient nor the attendant are able to tell her what medicines he is taking. Dr L interprets the man's visible symptoms as pointing towards Parkinson's, compounded by the diabetes, plus hyperthyroidism and hypertension. But without any record of his current regimen she does not want to risk any adverse drug interaction by writing a new prescription. She tells the attendant to take the patient to the neurology OPD and to return to see her next week. I look forward to seeing them again, but they don't turn up at the following week's OPD, which is also my last. According to Dr L, this is a classic case of 'episodic care', in which the absence of a coherent medical record and a primary physician conspire to splinter a patient into a constellation of symptoms responded to differently by different specialists. For this patient so far, 'treatment' seems to be defined more as the act of presentation to a doctor than the receipt of coherent care.

The AIIMSonian's burden

I think after coming here, your expectations are really high, so people expect a lot from you. They want you to become...you are not supposed to remain a MBBS. Even if someone wants to remain, there is a lot of pressure from parents, or from friends. – Ashish

I am doing MBBS from AIIMS, and after MBBS or PG, even in some community centre or district hospital, I am not using myself as a whole. If

I do super-specialty, I will become one of the few specialists, only for complicated diseases. If I am at AIIMS, so I should be like one of them.
– Nikhil

Recall the admissions process discussed in chapter 4. We saw that the trajectory for getting into AIIMS as an MBBS student begins, for many, at a very young age and is, I argued, informed by the possession of capitals which determine in their respective ways educational opportunities and potential horizons. The reputation of AIIMS, in the imagination of students, their families, and the public, is central to the commitment to preparation demanded by the entrance exam. With this in mind, it may be unsurprising to encounter AIIMS students for whom satisfaction is unlikely while there are still further, more competitive, targets in sight. Reputations are at stake, as Azam explained:

We can work, it's fine. You can be a part of a big hospital. But without specialization your name won't come anywhere. So the major thing is that there is some social stigma...other thing is that people are getting more and more degrees. So this is a competitive world, you have to cope up with that.

In this sense, the achievement of admission is not a singular event with various enduring consequences (Long & Moore 2013: 13), but rather the first in a chain reaction of achievements, each of which is pursued in reference to the last. This state of constant achievement befitting an AIIMSonian is not always comfortable. Rahul's father had worked for several years as a general practitioner before pursuing a postgraduate qualification. But Rahul felt that, appealing though a break may have been, the challenge of resuming studying would have been too great. 'I have been studying since school,' he said. 'It's a cycle going on.' A senior resident told me that he felt his career had involved very little conscious decision making. 'I never thought...I just thought that I have to do this, I have to do this, and things went on their way.'

Remaining the best

These kids have been told that they are the best 36 students in the whole country. I mean, what could you tell them to persuade to be the local community guy...right? – Anjali

In his work on ageing in India, Lawrence Cohen (1998) describes a narrative of the Fall that laments the gradual dissipation of the joint-family living arrangement, and the relationships it connotes, at the mercy of the three impersonal and unstoppable forces of globalization, Westernization, and urbanization. This discourse of transition from a golden age to a corrosive present expresses the anxieties of middle class society grappling with the variable demands and definitions of modernity. A similar discourse pertains to the history of medical care, illustrated through the devaluation of general practice, and family medicine. This narrative holds that once upon a time everyone had a local family doctor, who attended to multiple generations of the same family, and was considered virtually part of the family, invited home to celebrate weddings, and festivals (Porecha 2014, for example). This narrative is firmly rooted in the urban middle-class; some of my interlocutors were keen to stress that the family doctor phenomenon survives in smaller towns, as though defending them against accusation of the ethical erosion of personal relationships underway in the city.

As the last generation of these family doctors dies, there is no one to replace them, the story goes, and patients are left with little choice but to approach venal (super-)specialists who overcharge for unnecessary tests and are motivated more by money than concern for the patient (Fernandes 2006: 134). This nostalgia is the counter-narrative to that of patient demand for super-specialized treatment, and one which, anecdotal though it is, may be the precursor to a revival of family medicine under corporate auspices, as existing private healthcare brands recognise the market potential.

Family medicine entails its own postgraduate qualification, and is therefore not the direct equivalent of an MBBS doctor. It is common, however, for an MBBS doctor to undertake a postgraduate course in family medicine

alongside her general medical practice. India's National Health Policy 2002 (GoI 2002) expressed a need to prioritize family medicine, but the articulate policy went the way of so many others, and the draft National Health Policy 2015 (GoI 2015) does not address the same issue. The more fundamental impediment, however, is that family medicine is not a required component of the MBBS curriculum as stipulated by the Medical Council of India. Nor is it taught at AIIMS.¹⁸⁴ While the National Board Diploma course produces 200 annual graduates in family medicine, the MD programme remains extremely small, with only two seats offered annually at the Government Medical College in Calicut. The MCI – a body comprised entirely of specialists – has been accused of a vested interest in preventing the establishment of family medicine for fear of its gatekeeping role stemming the flow of patients seeking specialist treatment directly (Jacob 2016; Jeffrey 1988; Leeming 2001; Turner 1987: 131–56).

Anjali encountered family medicine as a potential career only when she began to explore options under her own steam. As she put it to me, 'even if we were interested in family medicine, we wouldn't know, because we aren't exposed to it.' Even an unusual student such as Hari, who planned to be a general practitioner at home in Calicut, the place with India's only two MD seats in family medicine, was unaware of this option and maintained that he would need to study for an MD in internal medicine. When I asked her about the likelihood of an AIIMS student pursuing a career in family medicine, Anjali parsed her view of the situation as follows:

I've interacted with students from England and everywhere, I've done projects with them and I realized for them family medicine is actually another residency. I mean, you have a residency in family medicine, and then you can stop there. It's actually considered quite good, you know you are not, like, 'family medicine, pssht.' So the thing is for us, at least in AIIMS, no one wants to be the general guy, he wants to be the one who is at the apex of his particular field and the only way to reach there is by super-specializing. I mean who are you when you are a family medicine

¹⁸⁴ The Department of Community Medicine at the six newly created AIIMS has had 'and Family Medicine' appended to its title, but no family physicians have been recruited to the faculty, not least because AIIMS does not recruit graduates of diploma programmes administered by the National Board.

guy, you are just another doctor in a small locality. Secondly everyone looks at finances and everything. No family medicine doctor makes any good amount of money. While when you are doing a super-specialized procedure, you can charge as your fantasy wishes. So yeah, I mean that's something that's going to be...that was predictable at the very onset of...when you join medicine, or even when you take up biology.

A former AIIMS director I interviewed offered a more succinct appraisal: 'AIIMS killed the GP.'

As I noted in chapters 1 and 2, following its establishment in 1956, AIIMS was not supported by the primary and secondary care infrastructure necessary for it to function as the referral institute for tertiary care that it was intended to be. I asked the former director when patients first began appearing at AIIMS with symptoms requiring primary care. 'Day one. It just increased. There was nothing you could do.'¹⁸⁵ The only educational advantage of this situation was squandered, the director said:

Now the only saving grace was...the undergraduates learnt primary care also. Otherwise the graduates of AIIMS would learn only tertiary care. But as medicine developed, specialties developed and super-specialties developed, the basic material in AIIMS was so good that they could very easily slip into specialties and super-specialties. Of the 50 students that got in there, I think maybe all 50 of them would do postgraduation. So what did we do? We killed the GP. So these are mistakes that were made. We did not see GP as a specialty; we did not see emergency medicine as a specialty. But we saw all the cardiac, neuro, nephro, what have you, as our own specialties and we created all those. But we killed the GP and we killed emergency medicine.

Madan (1980) heard similar criticisms in the 1970s. 'The emphasis on specialties and superspecialties produces doctors who are unwilling or unable to deal with the most common disorders and therefore most patients,' one faculty member said (84). Another told him that 'right from its inception, the Institute has had a highly trained and speciality-oriented faculty. The result is that we have here zealots cultivating their specialties and a sound general

¹⁸⁵ The fact that by 1974–75, AIIMS was already seeing over 450,000 outpatients a year testifies to this rapid growth (Madan 1980: 45).

education suffers by default. How can you produce good doctors without emphasizing *general* medicine and surgery?’ (ibid., original emphasis).

In the previous chapter I introduced the concept of ‘patient labour’ to describe how AIIMS students benefit from exposure to a very large number of patients with diverse conditions. This idea resurfaces here in relation to the claim by the former director that AIIMS bears responsibility for the demise of the general practitioner, despite the advantages of student exposure to primary care. In turn, this feeds into my contention that AIIMS is complicit in the broader healthcare landscape by illuminating the fact that the value patients add to students’ education is not converted by the institution into the attribution of value to the medical generalist whose skills may alleviate the demand for non-tertiary treatment at AIIMS. Too little attention was paid to questions of social accountability at AIIMS, Dr L told me. The Institute took more pride in students’ USMLE results than in those who went to work in primary care, she said, and the lack of role models was another impediment to the pursuit of alternative careers.

Weber described a dual process associated with the establishment of value – at one level, there is a tussle between members of a particular group (such as doctors), who vie ‘over their own peculiar notion of esteem,’ while at another ‘there is a larger struggle within the society as a whole to establish that particular notion of esteem, and the style of life with which it is associated, as the highest or most legitimate value’ (Weber 1978: 205–307, cited in Graeber 2013: 226). In her work on psychiatry in North India, Sarah Pinto describes legitimacy as ‘an arrangement of ideas’ that conditions ‘postcolonial conversations about medicine’ (2015: 6). The language of medical value also contains notions of legitimacy, both of the types of medicine that are practised and the types of people who practise them.

In chapter 3, I discussed the position of AIIMS as a definitive postcolonial institution in the Indian landscape, propelled as much by a Nehruvian techno-scientific vision of development as by the need for comprehensive healthcare. Narratives of development and modernity offer frameworks within which different people attempt to (re)craft themselves using technologies of the self

(Foucault 1988; Das 2003), whether through concepts of ‘hard work’ (Pandian 2008), making oneself bioavailable to the new medical technologies of the state (Cohen 2004), becoming a self-regulating consumer of proliferating healthcare goods and services, or being the ‘best’ sort of doctor. A student at AIIMS is therefore not only distinguished by the social achievement of having passed the entrance exam, but also by her consequent position at the vanguard of Indian medical modernity, an understanding of which implicates notions of value and legitimacy, which in turn influence the student’s imagining of her future self (Long & Moore 2013: 6).

The fragmented body (3)

A middle-aged woman enters the consultation room alone. She appears malnourished and disorientated. Her speech is vague, sluggish, and difficult to comprehend, although she says very little. Behind her ears linger a few traces of Holi pink and in my eyes her life briefly expands beyond the hospital, becoming bigger than the affliction that has brought her into this room. Among the papers she gives to Dr L are an insulin prescription and a note from a cardiologist. Given the communication difficulty, Dr L is not able to tell whether the woman has had certain tests done, or whether she is taking any medication. She tells me that the woman’s visit is an example of ‘doctor shopping’ – another symptom of unstructured care and the conventional wisdom that has come to attach to the pursuit of specialized treatment. But nothing about this woman suggests a capacity for such strategic pursuit of multiple opinions, and I wonder what is really going on, and what her story is.

The state and doctor-citizens

We have seen the various ways in which AIIMSonians are elevated into a medical elite, most significantly due to the ferocious competition for very few seats. We also know that all the student voices in this thesis are representative of an aspirational middle class. But within this broad bracket there is also great variation – illustrated perhaps most clearly by the experiential gulf between Anjali, upper-caste and the latest of five generations of doctors, and Dhananjay, ST, and from a semi-literate family. Nor do these variations have automatic corollaries when it comes to students’ aspirations.

In her work on the discursive relationships between ‘merit’ and caste identity at IIT Madras (see chapter 5), Ajantha Subramanian describes the ability of upper castes to erase the contribution not just of accumulated social and cultural capital, but also the role of the state in their achievements. Writing about the career aspirations of ‘IITians’, she notes that while the merit of earlier generations was established by becoming a scientific professional associated with the state, these days ‘merit has acquired a new valence as the transcendence, not just of politics, but also of the state and the public sector’ (2015: 300). Subramanian cites a professor who bemoans the fact that an IIT education has become little more than a subsidized ticket to a lucrative private sector salary, frequently outside India (*ibid.*: 292). This lament is also heard at AIIMS, although my conversations with students revealed more ambiguity about the public sector than that heard by Subramanian among IIT students and alumni.¹⁸⁶

Students’ experiences of the state differed, and therefore so did its influence over their aspirations for the future.¹⁸⁷ For a student from an affluent background, AIIMS was likely to be her first encounter with the state as a provider of education, and of healthcare. For those already acquainted with the state in this guise, however, AIIMS represented continuity and the ongoing accumulation of obligation alongside achievement.

Nikhil was very conscious of having accrued a debt to the state for his education at one of the Jawahar Navodaya Vidyalaya schools administered by the central government. He lived at the school from class 6 to 12 and recalled that they provided him with everything, from education and accommodation, the books he needed, down to clothes and a toothbrush. ‘And now I am here,’ he said, and asked if I knew that an MBBS at AIIMS only cost five and a half thousand rupees (‘in that also we have one thousand for hostel security, that will

¹⁸⁶ This may be another example of the distinction between engineering and medicine, the latter of which retains for some an aura of vocation and public service (even if this is not always warranted), despite its frequent coupling with engineering as an interchangeable career option (see chapter 4).

¹⁸⁷ Space constraints preclude my attending to the rich array of studies of state-citizen relationships in contemporary India. For examples see Das and Poole (2004), Fuller and Harriss (2001), Gupta (1995, 2012), Jayal (2013), Pinto (2008), Singh (2015a).

be refunded', he added). 'From class 6 onwards I have been totally government funded,' he said. Would this affect his future plans, I wondered. He nodded and confirmed that he would stay and practise medicine in India. '*Banta hai itna* [I owe this much]'.

Azam had not been to a government school, but he also explained his commitment to working in India as a means of repaying a debt he felt he had accrued through his highly subsidized training at AIIMS, the real value of which he maintained was between 1-1.5 crores.

So whatever I am getting is the money of the public. Whatever I do is, like, I do with their money. It's their tax, VAT, even if they buy a packet of biscuits they are giving some tax and that is the money behind my studies. So I have some duty and I have to pay them back.

The 'clash of perceived obligations' to family, profession, state and patients that Wendland observed among medical students in Malawi was also visible at AIIMS, as was a heightened sense of attachment to home among those intent on remaining in India (2010: 157–159). However, a commitment to staying at home was not an automatic corollary of a sense of obligation towards an idea of national welfare or development.

Historically, large numbers of AIIMS graduates have left India to establish careers elsewhere, predominantly in the US.¹⁸⁸ While considered unremarkable among current students, and treated as a matter of pride by the AIIMS administration according to Dr L (see above), emigration remains an emotive subject among older doctors who have spent their careers in India. An interlocutor in Madan's study describes the emigration of up to 80% of the early AIIMS batches as 'a colossal national waste' (1980: 82). 'What did you give back to this institution? To this nation? Nothing,' said Dr E when we discussed this. 'How many bricks have they laid here? None.'

Alongside their expertise, AIIMS doctors attract respect for the material sacrifice that they are believed to make by practising public sector medicine. There is an ethical assumption embedded in the decision of senior faculty

¹⁸⁸ See Kaushik et al. (2008) for a quantitative study of emigration among AIIMS alumni.

members to remain at AIIMS despite the allure of high private sector salaries, just as there is in the judgement of those who left for the US several decades ago, never to return. This trend has slowed in recent years, however; students repeatedly told me that the increasing opportunities for a comfortable life as a doctor in India made going abroad unnecessary. Others chose to stay at home to remain close to families and friends, even if the US still held some allure. Of those intending to go to the US, several students already had a support network of friends and family in place. A couple of students planned to study in the US and then return to India to practise, although this claim was often met with scepticism by others. Neha and Anjali both challenged the assumption of financial motivations for emigration – their ostensibly conventional plans disguised the pursuit of an independence denied them at home, as I explore in their stories at the end of this chapter.

Vivek was unique among the students I spoke with for having spent considerable time in the US while growing up. His experience had engendered an expectation of, and comfort with, global mobility akin to that found by Fuller and Narasimhan (2007) among IT professionals in Chennai. Vivek's perspective was that of a nascent global citizen, for whom distance and national borders were no impediment to the contribution he wished to make to India:

Even if I choose to live in the US, I don't think that there is any reason I will not be able to help out India, because it's an era of globalization. People do video conferences, people go here and there. They deliver lectures, they start seminars, they do workshops. I know an emergency physician who is a family friend in the US and he started emergency medicine departments in about four colleges in India. So it doesn't mean that you cannot help out India if you are not living here.

The growth of telemedicine in rural India suggests that this arrangement will soon also be applicable to doctors reluctant to leave urban centres (see below) but keen to contribute to the alleviation of illness among the country's poorest citizens.

Given that I was told that it was the new opportunities in the corporate healthcare sector that discouraged graduates from emigrating, there was little reason to assume that a desire to stay in India equated to a desire to work in the public sector. In our conversations, however, more students articulated a preference for public over private practice. On one hand, this challenges the critical narrative in which the government subsidizes the education of students who intend to seek employment in the more lucrative private sector. On the other, this preference often turned out to be the expression of an ideal that could not be fulfilled due to a range of structural and ideological impediments.

Rahul's desire to work in a public hospital was a direct consequence of the debt he felt he had accrued during his education, coupled with a distaste for profit-making through illness:

I'm not interested [in the private sector]. Because they charge you, just for a basic consultation, so many hundreds...and here we are doing this thing for free. So that would be a wrong thing on my part that I am exploiting my...the government is spending...I'm studying in 100 dollars and I am still taking so much money from the people who spent taxes on my education! That would be a bad thing. They have invested in me, so I need to pay back also. Obviously the service is not as good and sophisticated as provided by private...but when I go to work in a private, I will feel like I'm taking benefit of someone's disease, that he is suffering and I'm taking advantage of it. That is a bad thing to do, that is what I have been taught.

For Balraj, too, working in the public sector was a question of personal ethics that guarded against the corrupting nature, as he saw it, of private medicine:

I want to work in public sector because the kind of patients I want I will get only in these public sector hospitals. Because in private sector it's a very difficult job, and once you enter private sector you tend...I don't know why but your mentality becomes like you have to earn money only, you forget any humanity. So I don't want to carry that ethos in my life. So I want to work...if I get a chance I would like to work in AIIMS only. That is the best place.

The exceptional nature of AIIMS is reflected in its occupation of a unique category within students' aspirations. More than one student was inclined to pursue a private career for the sake of material comforts, unless a position at AIIMS arose, offering status and research opportunities in exchange for a lower salary.

Despite popular assumptions that the private sector offers an easier existence, several students were wary of stories they had heard about the demands placed on doctors by hospital management. Alongside a feeling that he would gain greater satisfaction from treating patients of lower socioeconomic status, Krish anticipated less anxiety in public practice:

Because no competition will be there during my practice. People will come, people will go, I will treat. But in private sector, the competition among the doctors is higher. Because to get the patients...if the patients are less, [doctors] will have problems with the management of the hospital. But in public sector, nothing like that. If we are sincere, we can do work even though the money we get is less, but satisfaction will be higher, stress level will be less. Happier life.

For Mihir, on the other hand, the only advantages of working in a government hospital were that he believed doctors were less threatened by litigious patients, and that he perceived the financial nexus between doctors and diagnostic facilities to be less significant in public hospitals. These beliefs illustrate an increasingly pervasive narrative of corruption in corporate hospitals, and a perception of wealthier patients becoming ever more likely to sue doctors on the grounds of malpractice (see Gadre & Shukla 2016). These supposed advantages posed their own constraints however, and Mihir was not sure he was willing to defend the marriage of medicine and ethics if it meant denying himself more lucrative opportunities:

So if you want to practise ethically...government is still better than private. But what I have seen is that it's not that rewarding. You can stick to your ethics for only some time, after that you feel you are missing out on a big part of...

Community medicine

The AIIMS Centre for Community Medicine is, as Wendland describes its Malawian equivalent, ‘something of a grab bag of epidemiology, ethics, psychology, and other topics’ (2010: 90). Most importantly, however, the centre is responsible for the Comprehensive Rural Health Services Project in once rural, but now peri-urban, Haryana. The CRHSP comprises a community hospital in Ballabgarh, a forty-five minute drive from the South Delhi campus, and primary health centres in two local villages. All MBBS students are posted to Ballabgarh for seven weeks during their fourth year, and for three months of their internship. For many of our students, Ballabgarh was their first experience of life beyond a city. I first met many of those featured in this thesis when I visited Ballabgarh in September 2015.

On one of these visits, I accompanied students to an *anganwadi* centre in Ballabgarh, which acts as an exemplar of the services prescribed under the central government’s Integrated Child Development Services (ICDS) programme. The walls of the centre’s small rooms were painted in turquoise distemper and adorned with the weekly menu, and with posters explaining various government schemes and exhortations to vaccinate children. One poster was a calendar of dates relevant to health policy. Students began to take close-up photos of it on their phones, and I could only assume that they were making a study-aid, preparing to revise the dates that they already knew would appear on the community medicine exam. This seemed to encapsulate one of two divergent reactions to the community medicine posting: for some it was a box to be ticked – a list of policy provisions to be revised, and an interesting glimpse into ‘village life’, with little bearing on their career aspirations. For these students, the non-clinical foundation of community medicine (which informed its low status in the postgraduate branch hierarchy) was unappealing.

As at the college Wendland studied in Malawi, ideas about medical knowledge at AIIMS place the highest value on curative, individualized medicine, ‘and not – despite the efforts of community health faculty – on public

health and preventative medicine' (2010: 108; Jayaram 1995). Anjali summarized the general perception of community medicine among her peers:

...it's pretty underwhelming, yeah. You talk to anyone about community medicine and they will be like, there is this book, and you are supposed to read about sanitation and mosquitoes. Like who wants to know about that and how to make a toilet? I mean we are going to be people who are going to cut out appendixes in five minutes! It's seen as a thing that needs to be completed in order to reach the goal of cutting out appendixes.¹⁸⁹

This appraisal was borne out by the fact that few of the junior residents in community medicine had chosen the branch as their first choice – a fact that faculty were well aware of. For some, it was their only chance of studying at AIIMS, and the institution trumped the branch. This was true of Karthika, who, we learned in chapter 4, had abandoned any hope of getting a seat in her preferred branch (internal medicine), because securing the necessary top ten ranking in the postgraduate exam was 'not possible'. For others, it was a stopgap while they studied to retake the postgraduate exam in the hope of getting a higher rank and a preferable choice of branch. And for a minority, community medicine was where they wanted to be.

The perception of community medicine as a branch for those who failed to get placed in preferable departments is not new, as Madan (1980) illustrates. Madan conducted his study of AIIMS doctors in the 1970s, which he describes as 'a period of change and doubt', as the institution began to place more emphasis on community medicine. Some of his interviewees agreed with this approach, lamenting 'the failure of college syllabuses to impart to the medical student a sense of social awareness and responsibility' (68). Other interlocutors were unhappy with the reorientation, arguing that AIIMS was built to produce urban specialists, and referring to the community medicine outposts as 'useless showpieces' (ibid.) – a complaint that belies the nostalgic view of an epistemic break between the altruism and frugality of the pre-1991 era, and its consumption-fuelled aftermath (Lukose 2009).

¹⁸⁹ Anjali was not, however, speaking for herself here – she had developed a keen interest in the possibilities of a career in public health during her time at Ballabgarh, as we will see below.

For Mihir, and perhaps shedding further light on the ethical ambivalence he expressed above, the Ballabgarh posting had little impact on his worldview or his future plans, at least in the medium-term:

Generally you feel that when you are in such kind of places like AIIMS and you know what facilities are available and you know what you can do with them, you would want to work in the best possible sense. And we aren't that much socially conscious that we will be moved by all that, you know poverty, or basic things being absent in those regions. It really doesn't move us that easily. So yeah, our stint in Ballabgarh it increased our awareness definitely. But I won't say that it convinced me to go into public health, as of now. Maybe if I am say financially secure and totally content at 40 or 45 I'd think of that. But not now.

During a similar discussion in the 1970s, Madan was asked by one of his interlocutors, 'Why am I expected to be like Jesus Christ?' (1980: 71).

Waste, absence, lack

In her work on attainment in post-socialist Vietnam, Susan Bayly writes about the 'complex geographies' (2013: 177), the temporal and spatial dimensions, of achievement. We can also understand achievement and aspiration at AIIMS through a spatial lens, via the demarcation between the rich prospects of the city, and the absences perceived to lie beyond. In her work on doctors in Rajasthan, Jocelyn Killmer (2014) describes absence as the defining lens through which her interlocutors understand the rural landscape, including its people (also see Pinto 2008).¹⁹⁰ At AIIMS, students cited notoriously poor medical infrastructure as the main obstruction to working in the public sector beyond the city.¹⁹¹ A lack of security, particularly for women, of a support network, and

¹⁹⁰ There is a long established trope of the Indian village as viewed from the city. See Jodhka (2002) for how perceptions of the village differed in the political thought of Gandhi, Nehru, and Ambedkar; the film *Swades* (2004, dir. Gowariker) for the response of a returning Non-Resident Indian to rural India; and the novel *English, August* (Chatterjee 1988) for the story of an urban civil servant being posted to a village.

¹⁹¹ See Patel et al. (2015: 2426–2427), and Powell-Jackson (2013) for an overview of the multiple failings of primary health centres in particular.

of surrounding infrastructure were also features that underscored the comparative abundance of the city (also see Rao et al. 2010).

It bears noting that not all doctors reject rural practice. In their study of doctors in rural Chhattisgarh, Sheikh et al. (2012) found that personal ties to the region, co-location with spouses, an ethic of public service, positive relationships with colleagues, and (small) financial incentives were important factors influencing a commitment to rural practice. A more recent article drawing on interviews with this same cohort, however, stresses ongoing needs including facility improvements, increased security, improved housing, access to better schools, ongoing training, and recognition of their work by the relevant administrations (Sheikh et al. 2016).

The perception of a particular action as imbued with value is often arrived at by implicit comparison with its opposite (Graeber 2001: 84). For example, value accrues to one career by virtue of it being steadily drained from (or having never been present in) an alternative. In a similar way, through its neglect of public healthcare beyond the cities, the state appears to collude in the production of value attached to urban, super-specialized, and usually private, medical practice. Students regularly held the state responsible for the unsuitability of a public sector career for an AIIMSonian:

The public health system is more...the government, I don't know, they expect too much. As I said, the primary healthcare system, they don't have enough, as I said they don't have ECGs, X-rays or anything... If they want, if they expect an MBBS student to go over there, an MBBS doctor, and practise, so you have to give him enough opportunities to practise what he has gained all five years. But the government won't...that is why most people don't want to go over there. And, like, the pay is not an issue at all, because in Delhi and Haryana area, the pay is enough. – Vipul

Claire Wendland suggests that '...biomedical technologies may also shape values even when they are absent: that is, they alter the medical imaginary, and in so doing, they alter its economy' (2010: 197-198). In India, the value shaped by absent technology helps to produce the (il)legitimacy of particular types of medical practice. It is not my intention to suggest that concerns over a lack of

technology are unfounded, or that highly technologized medicine should be considered 'divorced from affect, nor from "caring"' (DeVecchio Good 2011: 324). Rather, I am interested here in how its absence beyond urban centres informs a perception of state priorities and therefore of what is considered valuable medicine. Absent technology also implicitly informs perceptions of how the state comprehends and enacts (or neglects) a responsibility for the lives of the predominantly rural poor, whose bioavailability in the city may augment medical training, but who are rarely the recipients of similarly competent care at home (Gupta 2012; Pinto 2008; Singh 2015a).

State neglect of the public sector emphasizes the unique value of an AIIMSonian by illuminating the type of medicine they cannot be expected to practise:

With the type of training we are given, if you go to a peripheral centre, you will be seeing mostly cases which won't utilize all the knowledge you have. We are given so much knowledge in these five years...plus maybe three years of postgraduate training – a person with so much knowledge, why would he want to waste all this effort he has put in? He will be able to do nothing, write paracetamol or something for everyone. – Mihir

For some, however, there seemed to be more at stake than the frustration of absent technology. There was a sense, in some comments, that even if the equipment necessary to providing effective frontline care was available, this was not the sort of medicine an AIIMSonian was meant to practise because it was insufficiently complicated (see Nikhil above). Mihir described it as a 'waste of effort,' while Nikhil spoke of not using himself 'as a whole' even if he were to work as a specialist in a district hospital. Rural practice was often associated with the symptomatic treatment of colds, fevers, and diarrhoea; with the prescription of rehydration salts or paracetamol, and the bandaging of minor wounds.¹⁹² It was not only a lack of equipment that discouraged students, then, it was also a

¹⁹² See Killmer (2014) for the frustrations of doctors working without necessary equipment in rural Rajasthan who feel their position has been reduced to one of triage.

perception of ‘rural illnesses’ – a lack of sufficiently complex conditions to do justice to an AIIMSonian’s training.¹⁹³

When we sit this conventional wisdom alongside the testimony of students in chapter 7 who considered themselves unequipped to practise any kind of medicine after the MBBS, the entwined notions of value, legitimacy, and the unfolding consequences of high achievement become apparent. Anjali alluded to it, but only Azam explicitly spoke of stigma, of his ‘name not coming anywhere’ if he didn’t compete with those considered most successful. To exit that ecosystem is to go from having one’s picture in the newspaper on entering AIIMS, to rendering oneself invisible in front of the audience through which one’s sense of value is confirmed (Graeber 2001: 76).¹⁹⁴ Certain individuals who buck the trend are occasionally heroized by the metropolitan elite, such as the AIIMS alumni who run the community health project *Jan Swasthya Sahyog* (JSS) in Chhattisgarh (see Ruddock 2015), but the vast majority of rural doctors are acknowledged only by their patients.¹⁹⁵

The materiality of achievement (Bayly 2013: 158) represented by certificates and newspaper articles proudly displayed on the walls of a home also expresses the fact that ‘attainment is more than the successes of a lone striving individual’ (161). Bayly describes ‘achiever collectivities’ (ibid.), by which we might understand the families, teachers, and peer groups that contribute to the achievement attributed to an individual AIIMSonian and to whom that individual may feel a degree of accountability. We might consider an acknowledgement of this web of obligation a useful revelation – akin to illuminating the forms of requisite capital that are obscured by a narrative of individual merit. But this also requires recognizing the ways in which such a

¹⁹³ Agall, this is not new. Discussing the same topic, one of Madan’s interlocutors responded: ‘It is a painful waste of talent and resources...you do not need specialists like us to cater to the routine medical care needs of the population’ (93–94).

¹⁹⁴ The film *Ek Doctor ki Maut* [The Death of a Doctor] (1990, dir. Sinha) depicts the symbolic death of a promising young research doctor when he is banished to a village having upset the political hierarchy by receiving personal acclaim for his discovery of a leprosy vaccine.

¹⁹⁵ Nor is this guaranteed to be a positive experience. In September 2016, a photograph circulated on Twitter of two men leading a funeral procession through a village, carrying a banner with a picture of a doctor’s face and Hindi text blaming her for the death of her patient. See Killmer (2014) for examples of doctors being threatened by the dissatisfied families of patients in rural Rajasthan.

network also has the potential to act as a constraint upon individual desires, influencing decisions and leading to unanticipated outcomes.

*

In Malawi, Claire Wendland observed a radicalization of some medical students as they encountered the shortcomings of a ‘pathological’ government and a ‘pathogenic’ national economy (2010: 182), which informed both the devastating poverty and illness that brought patients to hospital, and students’ own inability to consistently provide effective medicine in the face of resource constraints and a corrupt politics of healthcare (172–192). This status quo produced a sense of identification with patients; an alliance within a shared predicament that allowed for what we might think of as the ‘shared existential moments’ (Das 2015: 25) that I have suggested are uncommon at AIIMS.

Wendland notes the contrast between this student behaviour and that reported in the Global North, where research consistently highlights the ‘cynical talk’ about patients by students (Becker et al. 1961; Pollock 1996; Sinclair 1997).¹⁹⁶ Based on my research, I suggest that students at AIIMS hover somewhere in between these two orientations (as indeed does the hospital infrastructure and the socioeconomic nature of India itself). In chapter 6, I argued that the socioeconomic differences between doctors and patients are often reified through communication in the clinic, and that this has implications for how students think about medicine. In the same chapter, I explored how poor patients with little education are considered both an impediment to efficiency and a bioavailable educational resource. But we have also seen that students are cognizant of the shortcomings of India’s public healthcare system that compel patients’ journeys to AIIMS in large numbers, and that they are often sympathetic towards the conditions in which many of these patients live. The Malawian students, training in a resource poor hospital, consider themselves different sorts of victims of the same systemic failures that afflict their

¹⁹⁶ Samuel Shem (1978) immortalized this culture in his novel about medical training, *House of God*.

patients.¹⁹⁷ Wendland suggests that this empathic relationship is productive of a form of biological citizenship in which doctors can participate alongside patients:

If we understand the notion of biological citizenship as, to some extent, an instance of the traditional 'patient' role writ large (that is, a collective patient identity, based in shared biological vulnerability or pathology, and entitled to make therapeutic claims on the state), then we might also conceive a parallel reconfiguration of the traditional doctor role on the national or transnational stage. Here the doctor's responsibilities for diagnosis and treatment are exercised in relation not (solely) to the patient's body but rather in relation to the collective patient, the body politic. Where biological citizenship describes a strategic political use of the patient identity, mobilized as a collective to make collective claims upon the state, there is evidence that Malawian medical trainees made a parallel move on behalf of physicians in their articulations of being 'doctors for the people'. (2010: 203)

I wonder, however, whether it is only within a sense of shared straitened circumstances that a framework of biological, or medical, citizenship encompassing both doctors and patients can develop, or whether Purush was striving towards a similar identification when he described his understanding of the politics of Indian health:

[H]ealthcare has been like a luxury for people. So they are the kind of people, the ruling classes, they get good healthcare out of whatever institutions we have. They personally don't want to focus on it because they are not pro-people governments as such. Because they haven't come out of any movement as such, because their selection of the candidates or whatever, the selection of the government, that is not true democracy as we know. So when there will be broader movement, which will change the form of democracy, obviously the healthcare and education and everything will change. And even in isolation they keep these small pilot projects and movements which keep changing, some reforms. But I still think these reforms are not enough because anyway people are not interested in changing it, whoever is at the helm. They keep calling people who are doing this good job...they keep calling them and put them

¹⁹⁷ Further research might consider the extent to which medical technology at AIIMS both serves patients and acts to obscure the social and political determinants of illness and health that are so visible to the Malawian students in Wendland's (2010) work. More generally, what happens to a social determinants perspective in the age of the super-specialist?

in advisory board of government, but there is no use of that if you don't have the political will towards working and economically funding it, anyway. That poverty and neglect thing we talked about...so ultimately even if you focus on the primary healthcare but not focus on the people's overall standard of living and poverty, then also there is no meaning to that. So a holistic approach towards the thing and political dedication, economically, is needed. And that cannot come out of these kind of systems that we have right now.

We might also interpret Dhananjay's words as a commitment to a form of common citizenship through his suggestion that the responsibility for improving the ethos and practice of public healthcare should be shared between the state and medical professionals:

Government should make... their state primary health centres should be like, their conditions and environment should be like they can work there. Like at primary health centres, there are buildings but they don't have any, they don't even have an X-ray machine, to do an X-ray. They don't have medicines there, they have limited amount of medicines only. They have no beds...no doctor. The doctor is somewhere doing his private practice and he is getting his attendance done somehow and he is practising outside and he is earning money ... So somehow on our parts also, we should also think as a doctor, the health system is not a money-making business. Engineering, lawyer, businessman, they are. If you have chosen this profession then you should not be going behind money. You can't compare health in terms of money, someone's life in terms of money. I think it's on both, on our part and the government's part, to change the primary health system. We should also be ready to go there and work.

Both Purush and Dhananjay had undergone a form of political education at AIIMS, under the influence of former student leaders and particular faculty members. Inspired by JSS, mentioned above, a community health project established by AIIMS alumni in rural Chhattisgarh (Ruddock 2015), and similar services, Purush and Dhananjay intended to complete their postgraduate training and set-up similar projects of their own, focusing on the local while

fully aware of the unlikeliness of any forthcoming political sea change (Jacob 2016).¹⁹⁸

As you will recall, Purush and Dhananjay were, respectively, in the SC and ST reserved categories at AIIMS. Without further research, I am reluctant to draw any simplistic conclusions about the relationship between these affiliations and their relative politicization. While other students in reserved categories spoke of wanting to reform health and governance systems (Santosh and Kapil, for example), so did some of their upper-caste batchmates (including Anjali and Neha, below). Further, Priya, also in the ST category, while inclined to contribute to her ancestral village, was also keen to set-up a private dermatology clinic and spa in South Delhi, defying any easy assumptions about the automatic politicization of students with reserved seats.

*

Other students planned a different approach to resolving what they understood as India's problems. Shankar was already pursuing an entrepreneurial route, establishing a health education business with colleagues. When we spoke he was intending to apply to joint MBA-MPH programmes in the US, with Harvard as his top choice. Leaving medicine altogether and pursuing an MBA in order to enter the financial sector was an option students mentioned in a generic sense, but no one I spoke with intended to do this. Among those who planned to leave clinical medicine, all except Shankar and Anjali (at one point), were doing so in order to join the Indian Administrative Service (IAS), the most popular of the fiercely competitive civil services.

These students were deeply discomfited by encounters with the consequences of poverty and inadequate healthcare provision, whether at AIIMS in Delhi, in Ballabgarh (which, run by AIIMS, is well above average standards of provision in North India), or in Arunachal Pradesh, in Kapil's case. Unlike the

¹⁹⁸ The AIIMS administration in Delhi has been reluctant to establish an official connection with JSS, despite being repeatedly petitioned to do so. Knowledge about it spreads through word of mouth, therefore, denying its administrators the opportunity to act as the role models many faculty members acknowledge are lacking at the institution.

radicalization that Wendland observed among students in Malawi, however, these AIIMSians did not intend to enact their critique of the state through the provision of a patient-allied medicine, but by becoming part of the state machinery itself, in the hope of one day obtaining sufficient influence over its operation. Karan had come to this conclusion after spending several months at a community health centre in mountainous Uttarakhand upon graduating from AIIMS:

As a doctor I cannot work for the emancipation of the underprivileged. Because there are many factors, primarily the lack of basic amenities in interior Himalayas. Unless and until they are going to get that, I am doing nothing good for them. Nothing sustainable...there will not be a positive sustainability. You know I am there, I am trying to provide them healthcare to my best, but it's not going to be sustainable.

In the context of HIV/AIDS testing, Sheikh and Porter (2011) have written that many Indian doctors feel possessed of the 'negative power' necessary to resist governmental guidelines and act according to their own judgement (also see Kielmann et al. 2005), but not of the 'positive power' to voice their objections in public as a means to influencing policy-making itself. This, they suggest, is a symptom of an unproductive mutual exclusivity between public health discourse and medical practice in India. A perception of this divide seemed to inform the decisions of AIIMS students to leave medicine, although more often for the civil services than for a career in public health (see Anjali's story below for an exception), suggesting that their exposure to community medicine at AIIMS had failed to convince them of its potential influence over health policy and ground realities.

A shared ambition to join the IAS did not translate into a shared strategy for transforming Indian healthcare, however. While Neha (below) spoke of designing new medical curricula, Santosh (who we learned in chapter 4 feared marriage would impede his efficacy at work) was intent on promoting behaviour change. He intended to suspend poor performing doctors and teachers: 'If I scold them in public, I think that will work,' he told me.

Dr N, one of the faculty members who tried to (informally) introduce students to the political economy of Indian healthcare, was sympathetic to the instinct to leave medicine, but impatient with what he saw as naiveté: ‘They shouldn’t live in that fools’ paradise,’ he said. ‘They can’t do anything if they join the bureaucracy. They can do more as doctors.’ But who, in the educational and socioeconomic milieu of our students, is proof of that?

‘We need good role models at this stage,’ Dr E had already told me. ‘Very badly.’

Precluded futures

...the ultimate freedom is not the freedom to create or accumulate value, but the freedom to decide (collectively or individually) what it is that makes life worth living. (Graeber 2001: 88)

Efforts toward social justice and health advocacy start...with individual ethical reflection on the nature of one’s work, one’s place in the world, and one’s personal sense of effectiveness as a health professional, but such personal commitments can have effects far beyond one’s expectations. (Adams & Kaufman 2011: 318)

So far, this chapter has looked at influences on the aspirations of AIIMS students, and how they come to value certain prospective careers over others. In this final section, I tell the stories of two students and a faculty member as illustrations of challenges that preclude certain imagined futures and lead to alternative outcomes. These stories offer more examples of the limits to the freedom narrative, or the experience of AIIMS as a liminal space, as discussed in chapter 5, as well as illuminating the enduring legacy of the inherent status of an AIIMSonian.

Neha

January 2015. On the right hand door of the metal wardrobe in the corner of her small single room, Neha had taped a list. The list was composed of A4 sheets of

paper covered in tiny writing. The writing detailed the syllabus Neha needed to study in order to take the notoriously challenging civil services entrance exam. 'I put it here to motivate me to study,' she said, and laughed as I shuddered at the scale of the task she had set herself alongside completing the fourth year of her MBBS. I asked her why she planned to leave medicine. She replied that her Ballabgarh posting had introduced her to the healthcare needs of rural India, which she felt she would not be able to sufficiently redress as a doctor.

So, then I changed my mind. And now I'm looking at Indian Administrative Services, to bring in some change at the ground level. So that I can impact more people. If I become a doctor, I'll probably touch a few handfuls of lives, save them. But if I become an IAS officer, then I'll be able to change some policies. So that they can be helped.

One of her plans was to reform the medical curriculum:

I think I can help make a new curriculum, which is shorter than MBBS duration. Like we have a five-and-a-half year course – I think it is too prolonged. You can teach...like this entrance to the MBBS programme is also very tough and there are many students who are from poor background and cannot afford coaching. Coaching is a must for getting into this exam, I also took coaching, everyone takes coaching to get into colleges. So I can make some other programme, which is of shorter duration so that they can tackle the basic healthcare problems. And that the entrance should be easier, so that a lot many people can enter into that field.

Several weeks later, I met Anjali while I was interviewing students at the campus coffee shop. We chatted for a while about Anjali's own evolving plans, but when I asked about Neha's exam preparation, Anjali shook her head. Neha had abandoned her IAS plan to focus on the USMLE. Her family had begun mentioning marriage, and while her AIIMS credentials would be deployed in the matchmaking process, Neha feared that she would be married into a family that would exercise control over her career, and may not even permit her to work outside the home.

Neha didn't reply to my request to meet before I left Delhi, but I bumped into her outside the girls' hostel during a brief visit in September 2015. I said I'd

heard from Anjali that her plans had changed. She looked at me searchingly, as though unconvinced by her motives, and asked, 'What do you think?' I hesitated. The power of my position was expressed not through my status as a researcher in this case, but more through an affective dimension in which our prior encounters coupled with respect for the age gap between us – which placed me in a bracket more akin to an older sister than to an aunt or a maternal figure – translated into trust and the solicitation of advice about her future at a precarious juncture. I told her that I could see how complex the decision was, and that I understood that she might feel she would have greater freedom in the US. 'Yes,' she said, nodding and looking relieved. 'That's what.'

Anjali

I don't think at any point in the curriculum we are actually given a comprehensive introduction to how everything really works. Yeah, we are taught all the peritoneum folds that cover the rectum and everything, but no one really teaches us where the guidelines are coming from, what's going on at the international level, what kind of pressures are interacting, how policies are being made, who is devising the policy...No one really talks about it, because it's kind of...I mean I don't know, it's probably our fault and it's probably...it's a very multi-factoral kind of problem, it's nobody's specific fault in it. It's just that we come with this kind of conception that OK, I am going to open up people's brains and that kind of thing, I don't need to know all those kind of things. And the doctors are themselves practising physicians who are into whatever they do and they only talk about that. So there is no one who is going to tell you about this as a whole. The community medicine faculty tries, but fails. One, because no one really thinks it's very important to know all those kind of things. And secondly, I don't believe the faculty is very good at communicating it either.

As we know, Anjali was the latest of five generations of doctors in her family, and she found herself at AIIMS more by default than design, fully aware of the myriad ways in which the path to entry had been facilitated. When we first met, she was very uncertain of her future plans:

...just being a doctor is not what I want to be. Because if you are like a surgeon...or if you are a doctor at a very high level, you are just a doctor right? Not doing much beyond that in your life. I don't think I like it that much, for it to be the whole of my life. I decided 2015 was going to be about knowing myself. And realizing what I want to do.

Anjali, like Neha, had been inspired by the Ballabgarh posting, to the extent that she had begun to explore the idea of pursuing a Master of Public Health (MPH) after her MBBS.

I was like this is what I want to do, this is so amazing! I mean we have all the techniques and who is receiving them, just like 1 or 2% of the population. And I was like sure that this is what I want to do. Then obviously some sense was drilled into my head by my parents and everyone, that...

Anjali was visibly excited at the prospect of studying public health. Like Neha's view of the civil services, she saw it as a means to instigate change, and explained her motivation to tackle health inequalities as follows: '...there are a lot of people in the army, but the strategy making and pretty much the outcome of the war would be decided by the general. I mean, who wants to be in the army when you can be the general?'

The efforts by her 'parents and everyone' to 'drill some sense' into Anjali's head seemed to be running in parallel to her own explorations of what might be possible. 'At this point of time,' she told me, 'my aim is to talk to as many people as possible so I know what I can do with my life.' Before the revelation about her MPH ambitions, Anjali had told me that she planned to apply for an MBA. This, she later explained, was strategic: 'my parents don't think very highly of MPH, no one does. So I figured if I could at least get out of the country and do an MBA there I might end up in a more public health kind of set-up...' That her parents didn't think very highly of the MPH turned out to be an understatement. In a conversation a few months later, Anjali told me that her mother had declared that an MPH was a 'useless degree' and that anyone she had ever met with an MPH 'was an idiot'.

From her liminal position, Anjali's future was inflected with multiple possibilities, but this liminality, or freedom, was also threatened by the ultimate authority of her parents. Despite her public health conviction, she had not abandoned the prospect of clinical practice; when I asked which branch of medicine she might hypothetically pursue, it turned out that she had already taken the first stage of the USMLE exam. Bets were being hedged and relationships managed. 'I just might end up doing it, because if my mom calls me [and says] "Anjali! I think you should be a surgeon! Start preparing!" then I would do that. That's how I have been programmed...to obey my parents.' Choices here, too, had their complications. A while later, Anjali went to discuss her options with an uncle who was a former head of a surgical department. He told her that 'there are things girls can never do – such as surgery – because they have to raise kids.' She gave a slightly confused laugh. 'Which doesn't really seem right...' Value hierarchies, within and without medicine, seemed to intersect with social norms and family expectations until the path ahead appeared ever more opaque; imagined futures ever more precluded.

A while after our initial conversation, I bumped into Anjali at the campus coffee shop. Her new plan was to complete the USMLE and pursue her residency in the US, then to explore the public health option if possible. But she had also been warned that she was unlikely to stop at residency, given the 'Indian system of competition' and a 'constant striving for progression', and she acknowledged the potential truth of this. Her family wanted her to 'follow a conventional path first,' she said. Since a recent family wedding, Anjali's own engagement was on her parents' agenda; two female students in her batch had recently become engaged. 'I just mute the phone when the subject comes up,' she said. She could envisage her Indian future, could see herself being propelled straight into her parents' private practice, into marriage. 'Trapped,' she said. 'I can't do that.' As for Neha, emigration became a means of escaping suffocating expectations, but at the expense of an aspiration to work in the interests of those most marginalized by India's politics of health.

A few months later, Anjali had accepted that she would settle in the US. 'Even if I say I'll come back...no one comes back.' At least not until they are in

their fifties, with the stature of Naresh Trehan, she added. Trehan founded the multi-speciality hospital Medanta ('The Medicity') in Gurgaon, outside Delhi, in 2009, following a career as a cardiac surgeon in New York. He is considered to wield significant influence over the direction of government health policy (allegedly in the direction of private interests – see Krishnan 2015). Trehan and Prathap Reddy,¹⁹⁹ another cardiologist, and the founder of India's first corporate hospital chain, Apollo, are arguably India's most famous doctor-businessmen. Their impact on the landscape of private medicine is an indicator that the transformation of 'health, power, and other aspects of social life' (Holmes et al. 2011: 105) by clinicians can be understood from a variety of perspectives.

Anjali maintained that life in the US would allow her greater independence, and a more flexible training system would let her explore wider interests. And she wouldn't be leaving until 2018. Her parents were 'fine' with it, she said, 'as long as I get married', and to that end they were determinedly 'groom-hunting' (having overcome their disappointment that Anjali was no longer dating last year's postgraduate topper). Anjali said she saw their point – 'no one has gone there alone,' she said of her seniors – and she didn't mention muting the phone when the subject came up.

On paper, Neha and Anjali are just another two AIIMS graduates leaving for the US, earning the approbation of some and the respect of others in the process. Their early aspirations to instigate policy change in the interests of India's rural poor will be obscured by a narrative of ever-greater achievement befitting a graduate of AIIMS. And the courage of their pursuit of independence – their escape, if you like, which we might interpret as an effort to adhere to their personal definitions of value – will be reinterpreted as an expression of appropriate ambition.

One instinctive reaction might be regret at the strangulation of individual purpose, as the possibilities of liminality appear compromised by the demands of ongoing achievement. But perhaps the act of having imagined something else is less suggestive of a loss than of the potential of these young women to act in

¹⁹⁹ See Gupte's (2013) hagiography of Reddy that considers him responsible for 'the transformation of India.'

response to the contingency of their achievement as AIIMSonians and to continually reimagine their way towards a future that entails both challenge and compromise.

In Anjali's hostel room, beside her bed, she had written quotations on the wall. One was a line from Tennyson's *Ulysses*: 'How dull it is to pause, to make an end; to rust unburnish'd, not to shine in use!' Another was from Tolstoy's *Anna Karenina*: 'There was no solution, save that universal solution which life gives to all questions, even the most complex and unsolveable: one must live in the needs of the day, that is, forget oneself.'

Dr B

Finally, it was not only the current generation of AIIMSonians who faced dilemmas about the value of actions and potential futures. Dr B told me in an early conversation that as an AIIMS undergraduate several decades ago, he had looked for a rural job but been told there was nothing he could apply for.

I did make an effort to go and ask people if there were jobs which I could apply for in a rural area, and I was told that there are no jobs. I didn't know what to do. So I said OK. By the end of internship I decided surgery was the thing to do. And once you are in the rat race, then you are in the rat race, then it takes lot of effort to get out of that.

Decades later, the virtue attached to a long career at AIIMS notwithstanding, Dr B spends two weeks of his summer break volunteering his surgical skills at a rural healthcare NGO:

I think one of my motivations to keep going and working with these people comes from there, comes from that feeling of guilt of not having done what I wanted to do. So that's why I keep making efforts of trying to...I think even today if I had an opportunity where I could go and fit into a system, I'd probably move towards that, rather than work where I am.

Few people would accuse Dr B of seeking an easy life, or demonstrating a disregard for the marginalized by spending his career in the operating theatres and overcrowded clinics of AIIMS. But his own perception of the choices he has made is a reminder that the decisions our students make upon graduating are only the first in a ripple of consequences that stem from their having been part of the 0.01% of applicants who win a seat at AIIMS. As Long and Moore put it:

...achieving is at once intensely personal, relational and intersubjective, and can have ramifications on one's life and the matrix of relations one inhabits, both in the short-to-medium term and over the course of one's entire life. (2013: 13)

*

'It is value, then, that brings universes into being,' David Graeber suggests (2013: 231). The politics of medicine, and its associated value(s), is in some ways a microcosm of India's postcolonial tussle with its competing instincts about what the modern nation should be. The idea of what a *doctor* is and should be is the repository of a dissonance that allows the co-existence of the private sector doctor celebrated for her success while suspected of corruption, the benevolent rural doctor assumed to be incapable of higher achievement, the neglect of public healthcare by the state, and the expectation that an AIIMS student will embody the pinnacle of medical modernity through super-specialized urban practice. This dissonance was made explicit during Prime Minister Narendra Modi's speech to graduating students at the AIIMS convocation ceremony in October 2014. As widely reported in the press, Modi implored graduates to remember the debt to the nation they had incurred during their training, and concluded by saying, 'I leave you in hope that as children of mother India who have been lucky enough to study here, you will give back to society which has given you so much love' (Chatterjee 2014). Shortly after this moment, the Modi government cut the national health budget by almost 20% (Kalra 2014).

This chapter has explored aspiration among AIIMS students, and its implications for both personal trajectories and the Indian healthcare landscape.

I have thought about how value is attached to, or detached from, particular forms of medical practice by a complex dominant discourse, with resulting frictions between the competing desires of individual students, and between the needs of the Indian healthcare system and the expectations of doctors-in-formation at AIIMS. I have suggested that state neglect of public healthcare combined with the social status AIIMS-sons possess exerts a powerful influence over how medical practice is valued in modern India, with consequences both for how students think of their futures, and for how we understand the role of the country's most prestigious medical college as both productive and reinforcing of certain norms in the sociomedical landscape beyond its own gates.

Ultimately, we might understand the achievement of gaining a seat at AIIMS as both a form of value production and confirmation, which is augmented by the circumstances of medical training (including the 'patient labour' described in chapter 6), before 'rolling forward' as Long and Moore (2013: 6) put it, to inform not only what a student *desires* to do afterwards, but what she considers she *ought* to do, given the matrix of relations in which her prior achievement has placed her. Consequently, for a graduate to choose an alternative future to that which is expected might be understood as a decision to question not only the pursuit of a particular career path, but to challenge the legitimacy, the value, of the new conventional wisdom itself.

CHAPTER 8.

CONCLUSION: AIIMS IN IMAGINATION AND PRACTICE

In March 2016, I gave a talk at the Public Health Foundation of India (PHFI), with the title ‘AIIMS killed the GP’, alluding to the comment by a former director discussed in chapter 7. On arrival I was told that my title had caused ‘some consternation’²⁰⁰, and that the talk would now be followed by a debate in which members of the audience would be given the opportunity to rebut my proposition. Ultimately, the seminar convenor deemed a debate unwarranted, given the content of the presentation and the evidence that I was not quoting myself in the title. Perhaps in an effort to diffuse any lingering tensions, in his closing summary the convenor suggested that rather than being solely responsible for the death of the GP, AIIMS might be understood as representing a general trend underway throughout India. This avoided the question of whether, and how, AIIMS acts as an establisher of norms itself, providing a model of ideal medical practice for other institutions and their students. But it did illuminate the perception of AIIMS as a symbol, recalling my appropriation both of Pinto’s description of ‘institutional authority as a site of imagination and practice’ (2004: 355), and Gupta’s analytic approach to the state through ‘everyday practices’ and ‘discursive construction’ (1995: 375), as a means of understanding the All India Institute and the doctors it creates (see chapter 1).

In this thesis I have explored a variety of ways in which imagination and practice intersect to inform student experiences of India’s most prestigious medical college, from preparations for admission, to considering the future as an AIIMSonian. In these final few pages, I will revisit these themes, pulling them together in an effort to both illustrate my guiding argument that AIIMS is simultaneously insulated from, permeated by, and complicit in the sociomedical landscape beyond its gates, and to offer a response from an AIIMS perspective to the question about the kinds of people ‘formed through contemporary processes of clinical training,’ and how ‘these evolving subjects

²⁰⁰ The head of PHFI, Dr Srinath Reddy, is a former head of the AIIMS cardiology department, and was also physician to former Prime Minister Manmohan Singh.

[might] transform health, power, and other aspects of social life' (Holmes et al. 2011: 105).

*

In chapter 3, I traced the history of AIIMS and the multiple imaginaries that informed its establishment. We saw how the conception of the institution began in the final years of the colonial administration, but was finally brought to fruition by the government of newly independent India, predominantly under the direction of India's first secretary of health, Rajkumari Amrit Kaur. The mandate for AIIMS was ambitious and complex from the outset, envisioning a specialist, high-technology tertiary institution for the few that would also train new doctors to understand and respond to the healthcare needs of the many, as India strode determinedly towards development. For India's first prime minister, Jawaharlal Nehru, development was inextricably allied with science and technology (Arnold 2013; Phalkey 2013), as too was modernity, with its complex legacy of imperial knowledge (Prakash 2009).

AIIMS was intended to set a new standard in medical treatment and education in India – it was created to be the best – and making it so produced an institution that was a palimpsest of influences, simultaneously of India and the industrialized world, of an ethos both colonial and postcolonial, and founded on a concern for scaling the heights of technologized medical science while also expected to respond to the broader needs of a vast, sickened and impoverished nation. The recollections of a student and two faculty members in chapter 3 about the early days of AIIMS expressed the virtual immediacy of the institution's pre-eminence in the Indian medical field, and also the challenges that accompanied this position. Dr V explained how the lack of supporting infrastructure meant that AIIMS was prevented from being an exclusively tertiary institution by the large number of patients who sought primary and secondary care at the hospital, a challenged that has since multiplied.

As was perhaps predictable given its complex mandate, not everyone involved with AIIMS shared the same vision of how imagination should

translate into practice. T.N. Madan (1980) cites the concerns of Dr V. Ramalingaswami, director of AIIMS from 1969–79, expressed in his Jawaharlal Nehru memorial speech of 1975:

The distortions and incongruities that characterize the present system are many – the over-emphasis on doctors and specialists, on hospitalized individual medical care to the detriment of frontline primary health care of the masses of the people, curative services to the neglect of preventive services, urban orientation to the neglect of rural masses, the draining away of limited resources in the provision of advanced levels of health care to a relatively small segment of the population ... the distorted health manpower structure that mismatches the needs and, in the end, the wide gap that exists between the capabilities of modern medicine and the unfulfilled expectations of people ... Physicians in developing countries become estranged from their own people in the course of their training. The ablest men and women are not tackling the most acute and difficult problems. (1975: 8–9, cited in Madan 1980: 103)

Twenty years into its existence, Madan (1980) found a sense of identity crisis at AIIMS. Some faculty members felt that ‘a drastic redefinition’ of institutional goals was required, in the wake of its educational success and the greater attention being paid to its role in community medicine and, by extension, national development. Others disagreed and felt the priority should be to retain its tertiary specialist orientation, and to replicate the institution around the country (105).

This sense of unease persists among some present members of the faculty and administration of AIIMS who acknowledge the inherent challenge of an institution founded to reflect Indian parity in the global discourse of scientific progress while sensitizing skilled clinicians to the needs of their poorest fellow citizens. It is this postcolonial modernity, with its often uneasy encounters of people and ideas that informs both imagination and practice at AIIMS, feeding in turn students’ perceptions of exemplary medicine.

In the conclusion to his study, Madan suggests that ‘an institution must grow, not stagnate, and those who set it up may not be able to foresee the requirements of a future generation’ (79). In practice, AIIMS has grown unequivocally since 1956, according to every tangible numerical indicator:

budget, physical size, patients, faculty, exam applicants (hugely), and actual students (modestly). Most dramatically, AIIMS has multiplied, with six new institutions open since 2012 and many more at various stages on the drawing board. Space constraints have prevented me from addressing the expansion of the AIIMS network in any detail in this thesis. Feelings about the new institutions vary in Delhi, from seeing them as a threat to 'brand AIIMS', to viewing the opening of new government medical colleges as a positive development in an increasingly private landscape (see chapter 1). Building on some early material that I gathered during my fieldwork, I hope to expand on this theme in future, with a particular interest in if and how the idea and experience of AIIMS begins to shift as its identity fragments across multiple sites.

Whether AIIMS has grown in a strategic sense, beyond these numerical indicators – whether a vision of its purpose has evolved in line with India's most pressing needs, whether it has been guided by suitably equipped management in this regard, and indeed whether these developments are necessary – remains a matter of debate (see chapters 5 and 6). The polyvalence that Alice Street ascribes to Madang Hospital in Papua New Guinea is easily translated into the context of AIIMS: '[It] has never been one place; neither the care administered in it nor the bodies made visible through its practice have ever been of a single kind' (2014: 83). Nor, as this thesis has demonstrated, are the nascent doctors that it produces, despite the similar career trajectory pursued by many AIIMSonsians.

*

In chapter 7, I discussed the hierarchy of medical prestige that influences how AIIMS students think about their futures. In doing so I followed Graeber and others by noting that key to the establishment of value is an audience to confirm it (Graeber 2001: 76; Munn 1986; Otto & Willerslev 2013). Throughout this thesis we have seen examples of the exceptionalism of AIIMS being defined in comparison with other institutions. In the landscape of Indian medical

education, AIIMS is the best. In the preceding chapters I have not tried to refute this claim; rather I have been interested to explore how this reputation is fuelled, sustained, and challenged in both imagination and practice.

A comparative study across colleges would no doubt have drawn broader conclusions about medical students in contemporary India, but as I clarified in chapter 1, this was always intended to be a study of AIIMS, in which the institution itself has been understood as an influential actor. It has been an effort to heed Didier Fassin's call to ethnographically 'interrogate the obvious' (2013: 642) – to take a site so prominent in public imagination, and thoroughly imbued with assumption, and to explore how closer scrutiny might yield insight both into what it means for AIIMS to be the best, and what the consequences of this might be for the doctors it produces, and, by association, the Indian healthcare landscape more broadly. Understanding that the motivations of AIIMS students are neither singular nor homogenous was an important first step in this process.

The traditional equivalency of engineering and medicine as the most attractive careers for the Indian middle class persists in many families (Fernandes 2006; Wilson 2011). India's brightest students are taught that the arts, humanities, and social sciences are second tier preferences, for those who don't possess the capacity to study medicine or engineering. Of everyone I spoke with, Kapil, who we met in chapter 4, most exemplified the privileging of prestigious institutions over an attraction to either career. Having begun to study engineering at IIT and found he disliked it, Kapil successfully applied to AIIMS as an alternative. 'There was no motivation,' he said. It was not that he was 'interested or something like that.' This lack of interest had led him to begin studying for the civil services entrance exam, aiming to complete the triumvirate of achievement most valued by the Indian middle class.

For others, medicine was a default choice arrived at in other ways, whether imposed by parents as it was for Balraj, a seemingly inevitable consequence of being born into a family of doctors, as was the case for Anjali, or the result of a teacher's guidance in Dhananjay's example. But for others still, becoming a doctor was a longstanding ambition (occasionally pursued against

the wishes of parents) motivated by a desire to help people, to contribute to India's development, by a fascination with human anatomy, or by the attraction of a career with high social esteem. The persistence of the vocational dimension is what I suggested in chapter 4 differentiates medicine from engineering, and challenges perceptions of their direct equivalency as career options for young middle class Indians.

It is in the minds of aspiring students that the imaginary of the All India Institute is most potent, fuelled by messaging from the media and the medical establishment that filters into homes and schools. The reasons for students to study medicine might have differed, but their reasons for applying to AIIMS did not: it is the best.

At no point is an AIIMS applicant asked why she or he wants to become a doctor. That Kapil could win a place at AIIMS despite a self-professed lack of interest in medicine was entirely dependent on the nature of the entrance exam and the preparation and pre-requisites it demands. In chapter 4, I traced the legacy of colonial education policy and its associated pedagogical techniques into the present to demonstrate the continued emphasis on memorization or 'mugging up' as a technique for passing exams that demand little more than the regurgitation of 'facts'. The AIIMS entrance exam is considered more challenging for its inclusion of reason-assertion questions alongside the multiple choice questions that dominate college entrance tests, which allows the institution to feel confident in its capture of India's brightest aspiring medical students. Deshpande contends that by setting entrance standards excessively high, an institution like AIIMS can 'coast' on the back of students' abilities, confident that they will pass without the need for additional support (2013a: 38). As we also saw in chapter 5, this is not always the case, and some students, particularly those with weaker English, suffer from a lack of institutional intervention.

'The test doesn't really test how smart you are,' Anjali reflected. 'It tests how hard-working you can be.' More fundamentally, it tests an applicant's possession of a combination of economic, social, and cultural capital (Bourdieu 1986), which I have argued is crucial to her chance of being among the less than

0.01% of successful candidates. These capitals ensure the access to private, English-medium schooling, and the coaching classes now considered indispensable to the admissions process, not to mention the home environment – usually urban, middle class – and nourishment necessary to launch a child on the path to success. Anjali knew this, and considered her admission to AIIMS virtually inevitable as a result of ‘very comfortable circumstances, good schools, the best coaching ... I’ve never really had to fight.’

Anjali was unusual in this regard; other students I spoke with professed a sense of wonderment, occasionally bafflement, at the fact of their admission. Following the work of Long and Moore (2013), I characterized the moment in which a student receives news of their AIIMS admission as an example of achievement as an event, the experience of which ‘is both material and semiotic; concretely embodied and affectively charged, yet also known and elaborated through the work of fantasy and the imagination’ (11). The social life of this achievement pervades students’ experiences of the institution – as, too, the way AIIMS is viewed by students at other colleges – and exerts an influence over their aspirations, with, I suggested in chapter 7, consequences for the broader landscape of Indian healthcare.

The work of imagination continues with the bestowal of the clean integer of entrance exam rankings upon applicants, disguising behind a whole number the fact that, with individual results calculated to seven decimal places, it is plausible that the smallest difference between ranks could be one ten millionth of a mark. Following Satish Deshpande (2006), I argued in chapter 4 that rank acts as a tool of management through deception, suggesting a differentiation of achievement that disguises the homogeneity of marks and the circumstances from which most top-ranked students come, and also, via the politics of reservations (see chapter 5), confines an understanding of ‘meritorious’ achievement to those ranked 1–37. Drawing on work by Cohn (1987) and Appadurai (1993) on numbers in colonial India, and that by Guyer et al. (2010) and Stafford (2009) on the anthropology of numbers, I introduced the concept of a ‘biographical number’ as a lens through which to interrogate how rank might influence a student’s subjectivity.

Rank, as an expression of achievement, or perceived failure, contains within it a student's present impression of herself, and may also 'roll forward', to use Long and Moore's (2013) term, to influence the kind of future it feels permissible to imagine. We saw one example of this in Karthika, a junior resident, who said that it was 'not possible' for her to achieve the top ten ranking required to secure a seat in internal medicine at AIIMS, her preferred postgraduate branch. Rather than resitting the national postgraduate exam with the hope of securing a seat in medicine at a less prestigious college, Karthika had accepted her place in community medicine at AIIMS, making a strategic calculation that the unassailable value of a qualification from the All India Institute was worth the compromise of pursuing a less popular specialization (which, by the time we met, she had come to enjoy).

In chapter 5, I discussed the experiences of students once they had entered the gates of AIIMS. In doing so, I explored the narrative of 'freedom' that so many students used to describe their time at the Institute. Drawing on Turner (1967), I likened our students to neophytes at the liminal stage of an initiation – in this case, into the world of medicine, as doctors. Liminality allows, through the temporary suspension of standard social norms, for the envisioning of new possibilities (ibid.; Thomassen 2015: 46). Combined with autonomy, and a middle class (in the broadest sense), pan-Indian student body, a sense of liminality seemed to feed many students' perceptions of the exceptionalism of AIIMS, particularly when compared with other institutions.

But as my argument that AIIMS is simultaneously insulated from and permeated by social norms suggests, the institution can only be imperfectly liminal. In chapter 7, I narrated Neha and Anjali's efforts to pursue alternative trajectories to that of super-specialized practice in an effort to effect change in the healthcare landscape, only to find those futures precluded by the pressures of kinship and expectation embedded in their initial achievement of winning a place at AIIMS. They both tried, in the words of Holmes et al. to push back, 'or dialectically [craft] the field that [was] simultaneously crafting [them]' (2011: 105). The liminal experience – the 'freedom' – that had engendered and buoyed

their aspirations proved fragile, however, and the challenges of family and convention, uncontested within the gates of AIIMS, led to plans to study and practise medicine in the United States. While an observer might easily interpret Neha and Anjali's decisions as two more emigration stories of ambitious AIIMSonians, we saw at the heart of each personal narrative a strategy of present compromise in the pursuit of an enduring future freedom.

More immediately fragile was the role of liminality and imagination in the obfuscation of caste and the dynamics of reservations at AIIMS, as I explored in chapter 5. Anjali spoke of never having 'had to fight' for the circumstances of her admission to AIIMS. Dhananjay, by contrast, told me that 'you have to fight your own fight' within the institution's gates. This fight was against the explicit assumption by general category peers that he would get a postgraduate seat more easily by virtue of being in the ST category; it was to improve his English alone via YouTube; it was to 'change his personality for the better' – for which opportunity he was grateful to the liminal space of AIIMS. Purush, meanwhile, swung between rejecting caste definitions and allegiances, to acknowledging its unavoidable embeddedness in all areas of life. This included invoking the memory of their batchmate, an ST student who, exhausted by the fight, had hanged himself from his ceiling fan.

The enforced segregation and overt violence of ten years ago appears to have subsided at AIIMS. Caste slips from view more easily these days; discrimination has become more subtle, more discursive (Pinto 2008); encoded in talk of merit, hard work, equality of opportunity, and concern for the integrity of medicine (Deshpande 2013a, 2013b; Subramanian 2015; Still 2013). But it is still sometimes physically expressed through institutional neglect of students in need of support, and discrimination towards faculty in reserved categories. And it continues to periodically manifest through death in the shadow of buildings which house tireless efforts towards the preservation of life.

Holmes et al. (2011: 105) ask about the ‘kinds of people’ that are formed through processes of clinical training, and the influence they may go on to have. My approach to AIIMS deliberately sought, and has yielded, more insight into the influence of a discourse of doctoring on students, and their social experience of the country’s most prestigious medical college, than into the specifics of clinical training. Thus, in retrospect, it seems more honest to bend the original question to the purpose to which I have put it. This adaptation would ask ‘what kinds of people are formed through *learning to be a doctor at AIIMS*, and how might these subjects go on to influence health, power, and other aspects of social life?’

What this reformulation does is to reveal (certainly to myself as I have written) the essence of the thesis, and what it has to offer the medical anthropology of India – specifically the space where ethnographic work on medical education might sit. Which is an interrogation of how, by virtue of being India’s best medical college, AIIMS helps to inform a hierarchy of medical practice by producing and reconfirming dominant ideas of what it means to be the best kind of doctor.

It might appear, given the discussion so far, that AIIMS as it is imagined by aspiring students does not exist. In some ways this is inevitable, particularly for students whose expectations are set impossibly high by the ferocious competition for entry, the celebration of successful applicants in the media, and the circulation of the Institute’s reputation as the country’s best. It is also true in the sense that AIIMS as a coherent entity dissolves beneath an analytical gaze (Street 2014: 83), fracturing into multiple sites harnessed by an administrative structure and a shared allegiance to an institutional identity. Nevertheless, the reputation of AIIMS has always been nurtured, and the ideas it produces are sustained, by practice, even as imagination may inflate its exceptionalism.

While many students were disappointed by the pedagogical realities of AIIMS, they still acknowledged its superiority to other colleges in terms of resources (both financial and educational in the form of a diverse set of patients, see below), small class sizes, the quality of teaching by particular

faculty members, and opportunities for research and conference participation, alongside the social freedoms that many (if not all) enjoyed. Faculty members, even those such as Dr N who excoriated the Institute for its persistent discrimination towards those in reserved categories, noted that AIIMS remained a far better place to work than other colleges. And a large majority of patients were unequivocal about their expectation, and receipt, of superior care at AIIMS compared with other public (and often also private) hospitals.

In chapter 5, I introduced the concept of ‘patient labour’ as a means of understanding the dynamic in which students learn from the bioavailability (Cohen 2005) of large numbers of patients compelled to seek treatment for diverse conditions at AIIMS by state failure to provide adequate, accessible public healthcare beyond the city. We also saw how, while many patients of low socioeconomic status said that AIIMS doctors behave more respectfully than those in other institutions, and while certain faculty members make a particular effort, communication in the clinic tends to reinforce dynamics of class and power between doctors and patients (Ahearn 2012; Bourdieu 1991; Duranti 1997; Ram 2010). I argued that in the absence of formal teaching, the reliance on osmosis and mimesis of communication methods emphasizes the existential gulf between many students and the patients they treat and learn from, as well as imparting via a hidden curriculum (Hafferty 1998; Taylor & Wendland 2014) an impression of the characteristics that make a responsible patient and an effective doctor. These are all social facts of practice at AIIMS, which sometimes contribute to, and are sometimes omitted from, the institutional imaginary.

*

‘AIIMS is AIIMS,’ I was so often told during my fieldwork. For my student informants, the many meanings of this statement will endure throughout their lives. Whether as super-specialists, rural physicians, entrepreneurs, civil servants, citizens of India or elsewhere, they will retain in common the unique value bestowed upon an AIIMSonian at the moment of admission. Nevertheless,

perhaps it is the narrow contemporary imagination of the institution itself that prevents it from satisfying some students' more expansive ideas of what becoming a doctor at AIIMS could mean – that it might include the potential to become a transformative social actor as well as an expert technician.

If the faculty and administration of AIIMS deliberately worked to counter the stigma attached to careers beyond urban super-specialization, perhaps Anjali would have had more resources with which to convince her parents that their fears of a dilution of inherited capital were unfounded. If social science was not so thoroughly subordinated in Indian education, perhaps Santosh would have detected the transformative possibilities of a career in community, or general, medicine and not felt inclined to join the civil service instead. If role models pursuing a range of careers were invited to AIIMS, perhaps more students would have the confidence to interrogate the conventional wisdom that anything less than super-specialized practice is unbecoming of an AIIMSian. And perhaps integrated discussion of the many meanings of medicine and doctoring might shed light on institutional inequalities, encouraging an effort to be deliberately more insulated from, less permeated by, the more harmful norms of wider society. Would such changes make graduating from the country's best medical college more meaningful; might they make for an institution as exceptional in practice as it is in the imagination?

Counterfactuals, all, but I articulate them in an effort to reiterate the current preclusion of a variety of potential futures for students at AIIMS, as too for the institution as a whole. And to suggest, in conclusion, that of the tripartite lens through which I have viewed the All India Institute, it is the final argument that proves most consequential: that AIIMS is complicit in the sociomedical landscape beyond its gates. Perhaps this is also its tragedy: that its production and confirmation of certain norms and expectations ultimately acts to stifle rather than nurture the potential of individual young minds, and the transformative impact they might proceed to have on the politics of health and medicine in contemporary India.

BIBLIOGRAPHY

- Abraham, L. 2002. Bhai-Behen, True Love, Time Pass: Friendships and Sexual Partnerships among Youth in an Indian Metropolis. *Culture, Health and Sexuality*, 4(3): 337-53.
- Abrams, P. 1988 [1977]. Notes on the Difficulty of Studying the State. *Journal of Historical Sociology*, 1 (1): 58-89.
- Adams, V. 1998. *Doctors for Democracy*. Cambridge: Cambridge University Press.
- Adams, V. and S.R. Kaufman. 2011. Ethnography and the Making of Modern Health Professionals. *Culture, Medicine, and Psychiatry*, 35(2): 313-320. doi 10.1007/s11013-011-9216-0
- Adkoli, B. and R. Sood. 2009. Faculty development and medical education units in India: A survey. *The National Medical Journal of India*, 22(1): 28-32.
- Agamben, G. 1998. *Homo Sacer: Sovereign Power and Bare Life*. Stanford, CA: Stanford University Press.
- Ahearn, L. M. 2012. *Living Language: An Introduction to Linguistic Anthropology*. Malden, MA and Oxford: Wiley-Blackwell.
- Album, D. and S. Westin. 2008. Do diseases have a prestige hierarchy? A survey among physicians and medical students. *Social Science & Medicine*, 66: 182-188. doi: 10.1016/j.socscimed.2007.07.003
- Amrith, S. S. 2006. *Decolonizing International Health: India and Southeast Asia, 1930-65*. Basingstoke and New York: Palgrave Macmillan.
- Ananthakrishnan, N. and R. Sood. 2012. Curricula Battles: Is it Possible to Win the War even if a Few Battles are Lost? *International Journal of User-driven Healthcare*, 2(1): 82-85.
- Anderson, W. 2002. Postcolonial Technoscience. *Social Studies of Science*, 32(5-6): 643-658.
- Anderson, W. and H. Pols. 2012. Scientific Patriotism: Medical Science and National Self-Fashioning in Southeast Asia. *Comparative Studies in Society and History* 54(1): 93-113. doi: doi:10.1017/S0010417511000600

- Appadurai, A. 1993. Number in the Colonial Imagination. In *Orientalism and the Postcolonial Predicament: Perspectives on South Asia*, (eds.) C.A. Breckenridge and P. van der Veer: 314–339. Philadelphia: University of Pennsylvania Press.
- Arnold, D. 2013. Nehruvian Science and Postcolonial India. *Isis*, 104(2): 360–370.
- 1993. *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*. Berkeley: University of California Press.
- Aull Davies, C. 1999. *Reflexive Ethnography: A Guide to Researching Selves and Others*. London and New York: Routledge.
- Auyero, J. 2012. *Patients of the State: The Politics of Waiting in Argentina*. Durham and London: Duke University Press.
- Baer, H., M. Singer, and I. Susser. 2013. *Medical Anthropology and the World System: Critical Perspectives*. Santa Barbara, CA: Praeger.
- Bajpai, V. and A. Saraya. 2011. For a Realistic Assessment: A Social, Political and Public Health Analysis of Bhore Committee. *Social Change*, 41(2): 215–231.
- Bakhtin, M.M. 1981. Discourse in the novel. In M. Holquist (ed.) *The Dialogic Imagination: Four Essays*, C. Emerson and M. Holquist (trans.): 259–422. Austin: University of Texas Press.
- Bala, P. 2007. *Medicine and Medical Policies in India: Social and Historical Perspectives*. Lanham: Lexington Books.
- Banerjee, M. 2014. *Why India Votes?* Abingdon: Routledge.
- Banks, D. J. 2007. Minorities in American Anthropology: A Personal View. *Histories of Anthropology Annual*, 3(1): 222–246. doi: 10.1353/haa.o.0028
- Baru, R. 2010. Public Sector Doctors in an Era of Commercialisation. In K. Sheikh and A. George (eds.) *Health Providers in India: On the Frontlines of Change*: 81–96. Routledge: New Delhi.
- 2004. Abdicating Responsibility. *Seminar*, 537. <http://www.india-seminar.com/2004/537/ramabaru.htm> Accessed 22 September 2016.
- Baru, R., A. Acharya, S. Acharya, A.K. Shiva Kumar and K. Nagarak. 2010. Inequities in Access to Health Services in India: Caste, Class and Region. *Economic and Political Weekly*, 55(38): 49–58.
- Bate, S.P. 1997. Whatever Happened to Organizational Anthropology? A Review of the Field of Organizational Ethnography and Anthropological Studies. *Human Relations*, 50(9): 1147–1175. doi: 10.1023/A:1016961918626

- Baudrillard, J. 1998 [1970]. *The Consumer Society: Myths and Structures*. London: Sage.
- Bayly, C. 1996. *Empire and Information: Intelligence Gathering and Social Communication in India, 1780-1870*. Cambridge: Cambridge University Press.
- Baziak, A. T., and R.K. Denton. 1965. The language of the hospital and its effects on the patient. In J. K. Skipper, and R. C. Leonard (eds.), *Social interaction and patient care*: 272-277. Philadelphia: J.B. Lippincott.
- Becker, H.S, B. Geer, E.C. Hughes, and A.L. Strauss. 1961. *Boys in White: Student Culture in Medical School*. Chicago: University of Chicago Press.
- Bedi, A. 2016. AIIMS entrance exam: Vegetable vendor's son gets top rank in SC category. *The Hindustan Times*, June 16.
<http://www.hindustantimes.com/punjab/aiims-entrance-exam-vegetable-vendor-s-son-gets-top-rank-in-sc-category/story-JtlFq8reQPqQShZTnpGOUl.html>. Accessed 22 September 2016.
- Bell, K. 2015. Resisting Commensurability: Against Informed Consent as an Anthropological Virtue. *American Anthropologist*, 112(3): 1-12. doi: 10.14288/1.0223104
- Benei, V. 2008. *Schooling Passions: Nation, History, and Language in Contemporary Western India*. Stanford, CA: Stanford University Press.
- Beteille, A. 1991. The Reproduction of Inequality: Occupation, Caste and Family. *Contributions to Indian Sociology*, 25(1): 3-28.
- Bhatia, P. 2015. Government directs AIIMS to go bilingual. *Medical Dialogues*, 26 November. <http://www.medicaldialogues.in/government-directs-aiims-to-go-bi-lingual/>. Accessed 19 January 2016.
- Bloch, M. 1971. *Placing the Dead: Tombs, Ancestral Villages, and Kinship Organization in Madagascar*. London: Seminar Press.
- Bourdieu, P. 2010 [1990]. *Distinction: A social critique of the judgement of taste*. Abingdon: Routledge.
- 1991. *Language and Symbolic Power*. J.B. Thompson (ed.), G. Raymond and M. Adamson (trans.). Cambridge, MA: Harvard University Press.
- 1986. The Forms of Capital. In J. Richardson (ed.) *Handbook of Theory and Research for the Sociology of Education*: 83-95. New York: Greenwood Books.
- Bourdieu, P. and J. Passeron. 2015 [1977]. *Reproduction in Education, Society and Culture*. London: Sage.

Brada, B. 2011. "Not here": making the spaces and subjects of "global health" in Botswana. *Culture, Medicine, and Psychiatry*, 35(2): 285–312. doi: 10.1007/s11013-011-9209-Z

Bradbury, R. 1998 [1953]. *Fahrenheit 451*. London: HarperCollins.

Brijnath, B. 2014. *Unforgotten: Love and the Culture of Dementia Care in India*. New York and Oxford: Berghahn.

Business Standard. 2016a. Nadda urged to increase accommodation for AIIMS doctors. 28 July. http://www.business-standard.com/article/news-ians/nadda-urged-to-increase-accommodation-for-aiims-doctors-116072801224_1.html Accessed 22 September 2016.

--- 2016b. AIIMS at 60: Tree planted by Queen Elizabeth lost to termites. 2 October. http://www.business-standard.com/article/pti-stories/aiims-at-60-tree-planted-by-queen-elizabeth-lost-to-termites-116100200124_1.html Accessed 10 October 2016.

--- 2015. Sanjiv Chaturvedi: The man who uncovered AIIMS corruption. 29 July. http://www.business-standard.com/article/current-affairs/aiims-whistle-blower-sanjiv-chaturvedi-wins-ramon-magsaysay-award-115072900348_1.html Accessed 22 September 2016.

Carson, J. 2006. *The Measure of Merit: Talents, Intelligence, and Inequality in the French and American Republics, 1750–1940*. Princeton, NJ: Princeton University Press.

Castells, M. 2009. *The Rise of the Network Society: The Information Age: Economy, Society, and Culture Volume 1*. Oxford and Malden, MA: Wiley-Blackwell.

--- 1989. *The Informational City: Information Technology, Economic Restructuring, and the Urban Regional Process*. Oxford: Blackwell.

Chandra, N. 2013. Eight hours, 30 doctors and a new lease of life. Conjoined twins with fused chest, abdomen separated successfully at AIIMS. *India Today*, 10 July. <http://indiatoday.intoday.in/story/conjoined-twins-get-a-new-lease-of-life-at-aiims/1/290521.html> Accessed 22 September 2016.

Chatterjee, P. 2014. You must repay society's debt, Modi tells young AIIMS doctors. *The Indian Express*, 21 October. <http://indianexpress.com/article/delhi/you-must-repay-societys-debt-modi-tells-young-aiims-doctors/> Accessed 22 September 2016.

Chatterjee, U. 1988. *English, August*. London: Faber and Faber.

Chattopadhyay, S. 2015. 'I can't take it anymore': Sights and awful sounds from the labour room of an Indian public hospital. *Scroll*, 31 May. <http://scroll.in/article/729784/i-cant-take-it-anymore-sights-and-awful-sounds-from-the-labour-room-of-an-indian-public-hospital> Accessed 22 September 2016.

Chopra, R. 2005. Sisters and Brothers: Schooling, Family and Migration. In R. Chopra and P. Jeffery (eds.) *Educational Regimes in Contemporary India*: 299–315. New Delhi: Sage.

Chua, L. 2015. Troubled landscapes, troubling anthropology: co-presence, necessity and the making of ethnographic knowledge. *Journal of the Royal Anthropological Institute*, 21(3): 641 – 659. doi: 10.1111/1467-9655.12254

Chupke Chupke. Directed by Hrishikesh Mukherjee. 1975. Shemaroo, 2000. DVD.

Ciotti, M. 2006. In the past we were a bit 'Chamar': education as a self- and community engineering process in northern India. *Journal of the Royal Anthropological Institute*, 12(4): 899–916. doi: 10.1111/j.1467-9655.2006.00369.x

Clifford, J. 1986. Introduction: Partial Truths. In J. Clifford and G.E. Marcus (eds.) *Writing Culture: The Poetics and Politics of Ethnography*: 1–26. Berkeley: University of California Press.

Cohn, B. 1987. The Census, Social Structure and Objectification in South Asia. In *An Anthropologist Among the Historians and Other Essays*: 224–254. Oxford: Oxford University Press.

Cohen, L. 2012. The Big One. Paper presented at 41st Annual Conference on South Asia, University of Wisconsin-Madison. Available at: <https://followuidai.wordpress.com> Accessed 13 October 2016

--- 2005. Operability, Bioavailability, and Exception. In A. Ong and A.J. Collier (eds.) *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*: 79–90. Malden, MA: Blackwell.

--- 2004. Operability: Surgery at the Margin of the State. In V. Das and D. Poole (eds.) *Anthropology in the Margins of the State*: 165–190. Santa Fe: School of American Research Press.

--- 1998. *No Aging in India: Alzheimer's, The Bad Family, and Other Modern Things*. Berkeley: University of California Press.

Copeman, J. 2008. *Veins of Devotion: Blood Donation and Religious Experience in North India*. New Brunswick and London: Rutgers University Press.

- Corbridge, S. J. Harriss, and C. Jeffrey. 2013. *India Today: Economy, Politics and Society*. Cambridge: Polity Press.
- Coser, R.L. 1962. *Life in the Ward*. Ann Arbor: Michigan State University Press.
- Cowell, R.N. 1972. *The hidden curriculum: A theoretical framework and a pilot study*. Ed.d thesis Harvard Graduate School of Education.
- Crawford, D.G. 1914. *A History of the Indian Medical Service 1600–1913*. 2 Vols. London: W. Thacker.
- Crook, N (ed). 1996. *The Transmission of Knowledge in South Asia: Essays on Education, Religion, History, and Politics*. New Delhi: Oxford University Press.
- Crump, T. 1990. *The Anthropology of Numbers*. Cambridge University Press.
- Da Col, G. (ed.). 2013. Special Issue: Value as Theory. *HAU: Journal of Ethnographic Theory* 3(1). doi: <http://dx.doi.org/10.14318/hau3.1>
- Dandekar, V. 2013. Reservations in Medical Education in Maharashtra: An Empirical Study. In S. Deshpande and U. Zacharias (eds.) *Beyond Inclusion: The Practice of Equal Access in Indian Higher Education*: 95–144. New Delhi: Routledge.
- Das, J. 2016. India's informal doctors are assets not crooks. *SciDevNet*, 24 April. <http://www.scidev.net/global/health/opinion/india-informal-doctors-assets-crooks.html> Accessed 22 September 2016.
- Das, J. and J. Hammer. 2004. Strained Mercy: The Quality of Medical Care in Delhi. World Bank Policy Research Working Paper 3228. <http://www-wds.worldbank.org/> Accessed 22 September 2016.
- Das, V. 2015. *Affliction: Health, Disease, Poverty*. New Delhi: Orient Blackswan
- Das, V. and D. Poole. 2004. State and its Margins: Comparative Ethnographies. In V. Das and D. Poole (eds.) *Anthropology in the Margins of the State*: 3–34. Santa Fe: School of American Research Press.
- Datye, V., K. Kielmann, K. Sheikh, D. Deshmukh, S. Deshpande, J. Porter, and S. Rangan. 2006. Private practitioners' communications with patients around HIV testing in Pune, India. *Health Policy and Planning*, 21(5): 343–52. doi: 10.1093/heapol/czl021
- DelVecchio Good, M. 2011. The Inner Life of Medicine: A Commentary on Anthropologies of Clinical Training in the Twenty-First Century. *Culture, Medicine, and Psychiatry*, 35(2):321–327. doi: 10.1007/s11013-011-9217-z

--- 2007. The Medical Imaginary and the Biotechnical Embrace. In J. Biehl, B. Good and A. Kleinman (eds.) *Subjectivity: Ethnographic Investigations*: 362-380. Berkeley: University of California Press.

Deshpande, A. and T.E. Weisskopf. 2011. Does Affirmative Action Affect Productivity in the Indian Railways? Working Paper No.185, Centre for Development Economics, Delhi School of Economics. Available at: <http://www.cdeds.org/pdf/work185.pdf>

Deshpande, S. 2013a. Caste and Castelessness: Towards a Biography of the 'General Category'. *Economic and Political Weekly*, 47(15): 32-39.

--- 2013b. Caste Quotas and Formal Inclusion in Indian Higher Education. In S. Deshpande and U. Zacharias (eds.) *Beyond Inclusion: The Practice of Equal Access in Indian Higher Education*: 13-47. New Delhi: Routledge.

--- 2006. Exclusive Inequalities: Merit, Caste and Discrimination in Indian Higher Education Today. *Economic and Political Weekly*, 41(24): 2438-2444.

Dhar, A. 2007. AIIMS rejects Thorat report. *The Hindu*, 20 September. <http://www.thehindu.com/todays-paper/tp-national/tp-newdelhi/aiims-rejects-thorat-report/article1914478.ece> Accessed 4 December 2015.

Donner, H. 2008. *Domestic Goddesses: Maternity, Globalisation and Middle-Class Identity in Contemporary India*. Aldershot: Ashgate.

Donthi, P. 2016. From Shadows to the Stars: The defiant politics of Rohith Vemula and the Ambedkar Students Association. *The Caravan*, 1 May.

Douglas, M. 1986. *How Institutions Think*. Syracuse: Syracuse University Press.

Drèze, J. and A. Sen. 2013. *An Uncertain Glory: India and its Contradictions*. London: Allen Lane.

D'Silva, J. 2015. India's private medical colleges and capitation fees. *BMJ* 350. doi: <http://dx.doi.org/10.1136/bmj.h106>

Duranti, A. 1997. *Linguistic Anthropology*. Cambridge: Cambridge University Press.

Dutta, S. 2015. Kota rocked by 5 student suicides in 1 month. *The Indian Express*, 30 June. <http://indianexpress.com/article/india/india-others/love-affair-home-sickness-academic-pressure-behind-rising-suicide-cases-in-kota-police/> Accessed 22 September 2016.

Ecks, S. 2010. Spectacles of Reason: An Ethnography of Calcutta Gastroenterologists. In J. Edwards, P. Harvey and P. Wade (eds.), *Technologized*

Images, Technologized Bodies: Anthropological Approaches to a New Politics of Vision: 117–135. Oxford: Berghahn.

--- 2005. Pharmaceutical Citizenship: Antidepressant Marketing and the Promise of Demarginalization in India. *Anthropology and Medicine* 12(3): 239–254. doi: 10.1080/13648470500291360

--- 2004. Bodily Sovereignty as Political Sovereignty: 'Self-care' in Kolkata (India). *Anthropology & Medicine*, 11(1): 75–89.

Economic Times. 2016. Govt plans exit exam for all MBBS students. 27 July. <http://health.economictimes.indiatimes.com/news/industry/govt-plans-exit-exam-for-all-mbbs-students/53409969> Accessed 22 September 2016.

Ek Doctor ki Maut. Directed by Tapan Sinha. 1990. Shemaroo, 2012. DVD.

Enslin, E. 1994. Beyond Writing: Feminist Practice and the Limitations of Ethnography. *Cultural Anthropology*, 9(4): 537–568.

Farmer, P. 1999. *Infections and Inequalities: The Modern Plagues*. Berkeley: University of California Press.

Fassin, D. 2013. Why Ethnography Matters: On Anthropology and its Publics. *Cultural Anthropology* 28(4): 621–646. doi: 10.1111/cuan.12030

---- 2009. Another Politics of Life is Possible. *Theory, Culture and Society*, 26(5): 44–60. doi: 10.1177/0263276409106349

Fernandes, L. 2006. *India's New Middle Class: Democratic Politics in an Era of Economic Reform*. Minneapolis: University of Minnesota Press.

Finkler, K. 2004. Biomedicine globalized and localized: western medical practices in an outpatient clinic of a Mexican hospital. *Social Science & Medicine*, 59(10): 2037–2051. doi: 10.1016/j.socscimed.2004.03.008

Flinders, D.J., N. Noddings, S.J. Thornton. 1986. The Null Curriculum: Its Theoretical Basis and Practical Implications. *Curriculum Enquiry*, 16(1): 33–42.

Fortun, K. 2009. Foreword to the 25th Anniversary Edition. In J. Clifford and G.E. Marcus (eds.), *Writing Culture: The Poetics and Politics of Ethnography*: vii–xxii. Berkeley and Los Angeles: University of California Press.

Forum for Rights and Equality (FRE), AIIMS, New Delhi. 2015. Forum for Rights and Equality to The Secretary, Ministry of Health and Family Welfare. New Delhi, 19 January.

Foucault, M. 1994a [1963]. *The Birth of the Clinic: An Archaeology of Medical Perception*. New York: Vintage.

- 1994b. The Subject and Power. In P Rabinow and N. Rose (eds.), *The Essential Foucault: Selections from the Essential Works of Foucault, 1954–1984*: 126–144. New York: The New Press.
- 1988. Technologies of the Self. In L.H. Martin, H. Gutman, and P.H. Hutton (eds.) *Technologies of the Self: A Seminar with Michel Foucault*. Amherst: University of Massachusetts Press.
- Fox, R. 2000. Medical Uncertainty Revisited. In G.L. Albrecht, R. Fitzpatrick, and S. Scrimshaw (eds.) *Handbook of Social Studies*: 409–425. London and Thousand Oaks, CA: Sage.
- 1980. The Evolution of Medical Uncertainty. *Health and Society* 58(1): 1–49.
- 1957. Training for Uncertainty: Introductory Studies in the Sociology of Medical Education. In R.K. Merton, G. Reader, and P.L. Kendall (eds.) *The Student Physician*: 207–241. Cambridge: Harvard University Press.
- Froerer, P. 2011. Education, Inequality, and Social Mobility in Central India. *European Journal of Development Research*, 23: 695–711. doi:10.1057/ejdr.2011.43
- Fuller, C.J. 1997. Religious texts, priestly education and ritual action in south Indian temple Hinduism. *LSE Research Online*.
<http://eprints.lse.ac.uk/archive/00000468> Accessed 22 September 2016.
- Fuller, C.J. and J. Harriss. 2001. For an anthropology of the modern Indian state. In C.J. Fuller and V. Benei (eds.) *The Everyday State and Society in Modern India*: 1–30. London: Hurst and Co.
- Fuller, C.J. and Narasimhan, H. 2007. Information technology professionals and the new-rich middle class in Chennai (Madras). *Modern Asian Studies*, 41(1):121–150. doi:10.1017/S0026749X05002325
- Gadre, A. and A. Shukla. 2016. *Dissenting Diagnosis: Voices of conscience from the medical profession*. New Delhi: Random House India.
- Galbraith, J.K. 1998 [1958]. *The Affluent Society*. New York: Houghton Mifflin.
- Geertz, C. 2000. [1973]. *The Interpretation of Cultures: Selected Essays*. New York: Basic Books.
- Gesler, W.M. 1992. Therapeutic Landscapes: Medical Issues in Light of the New Cultural Geography. *Social Science & Medicine*, 34(7): 735–746.
- Ghosh, T. 2016. Making of an Engineer: My Journey Through School, Kota, and Depression. *Youth Ki Awaaz*, 30 June.
<http://www.youthkiawaaz.com/2016/06/kota-engineering-led-to-depression/>
 Accessed 22 September 2016.

- Gibson, D. 2004. The gaps in the gaze in South African hospitals. *Social Science & Medicine*, 59(10): 2013–24. doi: 10.1016/j.socscimed.2004.03.006
- Gilbertson, A. 2016. Cosmopolitan Learning, Making Merit, and Reproducing Privilege in Indian Schools. *Anthropology and Education Quarterly*, 47: 297–313. doi: 10.1111/aeq.12157
- 2014. ‘Mugging up’ versus ‘exposure’: international schools and social mobility in Hyderabad, India. *Ethnography and Education*, 9(2): 210–223. doi: 10.1080/17457823.2013.878512
- Good, B. 1977. *The heart of what's the matter: the structure of medical discourse in a provincial Iranian town*. Chicago: University of Chicago Press.
- Government of India (GoI). 2015. National Health Policy 2015 Draft. Ministry of Health and Family Welfare. <http://www.mohfw.nic.in/showfile.php?lid=3014> Accessed 22 September 2016.
- 2007. Report of the Committee to Enquire into the Allegation of Differential Treatment of SC/ST Students in All India Institute of Medical Science (sic). Available at: <http://www.nlhmb.in/reports%20aiims.pdf> Accessed 22 September 2016.
- 2002. National Health Policy. Ministry of Health and Family Welfare. <http://mohfw.nic.in/WriteReadData/1892s/18048892912105179110National%20Health%20policy-2002.pdf> Accessed 22 September 2016.
- 1954. Minutes of the second meeting of the Central Council of Health in Rajkot. Mimeographed. New Delhi.
- 1946. Health Survey and Development Committee, Vols I-III. Calcutta: Government of India Press. http://nihfw.org/NDC/DocumentationServices/Committe_and_commission.html Accessed 22 September 2016.
- Graeber, D. 2001. *Toward an Anthropological Theory of Value: The False Coin of Our Own Dreams*. New York: Palgrave.
- 2013. It is value that brings universes into being. *HAU: Journal of Ethnographic Theory* 3(2): 219–43.
- Gupta, A. 2012. *Red Tape: Bureaucracy, Structural Violence, and Poverty in India*. Durham and London: Duke University Press.
- 1995. Blurred Boundaries: The Discourse of Corruption, the Culture of Politics, and the Imagined State. *American Ethnologist*, 22(2): 375–402.

- Gupta, A. and J. Ferguson. 1992. Beyond "Culture": Space, Identity, and the Politics of Difference. *Cultural Anthropology*, 7(1): 6-23.
- Gupta, D. 2014. Tidy up Delhi's AIIMS before building many more across India. *The Times of India*, 21 July. <http://blogs.timesofindia.indiatimes.com/toi-editorials/tidy-up-delhis-aiims-before-building-many-more-across-india/> Accessed 22 September 2016.
- Gupte, P. 2013. *Healer: Dr Prathap Chandra Reddy and the Transformation of India*. New Delhi: Penguin.
- Gutschow, K. 2016. Going 'Beyond the Numbers': Maternal Death Reviews in India. *Medical Anthropology* 35(4): 322-37. doi: 10.1080/01459740.2015.1101460
- Guyer, J.I., N. Khan, and J. Obarrio. 2010. Introduction: Sensations of the Number Frontier. *Anthropological Theory*, 10(1-2): 36-61.
- Hafferty, F. 1998. Beyond curriculum reform: confronting medicine's hidden curriculum. *Academic Medicine*, 73(4): 403-407.
- Hafferty, F.W. and R. Franks. 1994. The Hidden Curriculum, Ethics Teaching, and the Structure of Medical Education. *Academic Medicine*, 69(11): 861-871.
- Haller, D. and C. Shore. 2005. *Corruption: anthropological perspectives*. London: Pluto.
- Hardiman, D. and P.B. Mukharji (eds.). 2012. *Medical marginality in South Asia : situating subaltern therapeutics*. London, New York: Routledge.
- Hasan, Z. 2009. *Politics of Inclusion: Castes, Minorities, and Affirmative Action*. New Delhi: Oxford University Press.
- Heath, D., R. Rapp, and K.-S. Taussig. 2008. Genetic Citizenship. In D. Nugent and J. Vincent (eds.), *A Companion to the Anthropology of Politics*: 152-167. Oxford: Blackwell.
- Hindustan Times*. 2015. Meet AIIMS MBBS entrance topper: Haryana boy Navsheen Singhal. 19 June. <http://www.hindustantimes.com/education/meet-aiims-mbbs-entrance-topper-haryana-boy-navsheen-singhal/story-UV59yoDAMIkn5fK4oRgzyJ.html> Accessed 19 June.
- Holmes, S.M., A.C. Jenks, and S. Stonington. 2011. Clinical Subjectification: Anthropologies of Contemporary Biomedical Training. *Culture, Medicine, and Psychiatry*, 35(2): 105-112. doi: 10.1007/s11013-011-9207-1
- Holston, J. 2008. *Insurgent Citizenship: Disjunctions of Democracy and Modernity in Brazil*. Princeton: Princeton University Press.

Hull, M.S. 2012. *Government of Paper: The Materiality of Bureaucracy in Urban Pakistan*. Berkeley: University of California Press.

Illich, I. 1982. *Medical Nemesis: The Expropriation of Health*. New York: Pantheon Books.

India Today. 2015. 17 kg tumour removed from woman's abdomen. 4 March. <http://indiatoday.intoday.in/story/aiims-doctor-remove-17-kg-tumour-from-bihar-woman-abdomen/1/422254.html> Accessed 23 September 2016.

Inhorn, M. 2004. Privacy, Privatization, and the Politics of Patronage: Ethnographic Challenges to Penetrating the Secret World of Middle Eastern, Hospital-Based In Vitro Fertilization. *Social Science & Medicine*, 59(10): 2095-2108. doi: 10.1016/j.socscimed.2004.03.012

Iqbal, N. 2016. Kashmir pellet gun victims pin their hopes on doctors at AIIMS. 27 July. <http://indianexpress.com/article/india/india-news-india/kashmir-pellet-gun-victims-aiims-2938977/> Accessed 23 September 2016.

Jacob, K.S. 2016. Politics of Medical Education in India. *Economic and Political Weekly*, 51(12): 12-15.

Jaffrelot, C. 2002. *India's silent revolution : the rise of the lower castes*. London: Hurst.

James, A. 2015. Keralites Shine in Delhi AIIMS Union Elections, Win All Posts Except One. *International Business Times*, 23 July. <http://www.ibtimes.co.in/keralites-shine-delhi-aiims-union-elections-win-all-posts-except-one-640243> Accessed 23 September 2016.

Jamous, H. and B. Peloille. 1970. Professions or self-perpetuating systems? Changes in the French university-hospital system. In Jackson, J.A. (ed.) *Professions and Professionalization*: 109-152. Cambridge: Cambridge University Press.

Jayal, N. G. .2013. *Citizenship and its Discontents: An Indian History*. Cambridge, MA: Harvard University Press.

Jeffery, P. 2005. Introduction: Hearts, Minds and Pockets. In R. Chopra and P. Jeffery (eds.) *Educational Regimes in Contemporary India*: 13-38. New Delhi: Sage.

Jeffery, R., P. Jeffery and C. Jeffrey. 2005. Social Inequalities and the Privatisation of Secondary Schooling in North India. In R. Chopra and P. Jeffery (eds.) *Educational Regimes in Contemporary India*: 41-61. New Delhi: Sage.

Jeffrey, C. 2010. *Timepass: youth, class, and the politics of waiting in India*. Stanford: Stanford University Press.

- Jeffrey, C., P. Jeffery and R. Jeffery. 2005. Reproducing Difference? Schooling, Jobs, and Empowerment in Uttar Pradesh, India. *World Development*, 33(12): 2085–2101. doi: 10.1016/j.worlddev.2005.07.006
- Jha, D.N. 2014. No takers for seats in AIIMS Patna, Raipur. *The Times of India*, 8 October. <http://timesofindia.indiatimes.com/home/education/news/No-takers-for-seats-in-AIIMS-Patna-Raipur/articleshow/44646599.cms> Accessed 5 November 2015.
- 2012. Tribal student hangs self at AIIMS. *The Times of India*, 5 March. <http://timesofindia.indiatimes.com/city/delhi/Tribal-student-at-AIIMS-hangs-self/articleshow/12139294.cms> Accessed 23 September 2016.
- Jodhka, S.S. and K. Newman. 2007. In the Name of Globalisation: Meritocracy, Productivity and the Hidden Language of Caste. *Economic and Political Weekly*, 42(41): 4125–4132.
- Kafka, F. 2005 [1930]. *The Castle*. London: Vintage.
- Kalra, A. 2014. India slashes health budget, already one of the world's lowest. *Reuters*, 23 December. <http://in.reuters.com/article/india-health-budget-idINKBNoK1oY020141223> Accessed 23 September 2016.
- Kaur, R.A. 1956. Speech to Parliament, 18 February 1956.
- Kaushik, M., A. Jaiswal, N. Shah, and A. Mahal. 2008. High-end physician migration from India. *Bulletin of the World Health Organization* 86(1): 40–45.
- Kielmann, K., V. Datye, A. Pradhan, and S. Rangan. 2014. Balancing authority, deference and trust across the public–private divide in health care: Tuberculosis health visitors in western Maharashtra, India. *Global Public Health*, 9(8): 975–992. doi: 10.1080/17441692.2014.941898
- Kielmann, K., D. Deshmukh, S. Deshpande, and S. Rangan. 2005. Managing Uncertainty Around HIV/AIDS in an Urban Setting: Private Medical Providers and their Patients in Pune, India. *Social Science & Medicine*, 61(7): 1540–50. doi: 10.1016/j.socscimed.2005.02.008
- Killmer, J. 2014. Reluctant Villagers: Young urban doctors in rural north India. Paper presented at conference, *Producing Anthropology*, annual meeting of the American Anthropological Association.
- King, S. 1962. *Perception of illness and medical practice*. New York: Russell Sage Foundation.
- Kirkpatrick, J. 1979. *The Sociology of an Indian Hospital Ward*. Calcutta: KLM.

- Kleinman, A. 1988. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books.
- Kluckhohn, C. 1951. Values and value-orientations in the theory of action: An exploration in definition and classification. In T. Parsons and E. Shils (Eds.), *Toward a general theory of action*. Cambridge, MA: Harvard University Press
- Kuipers, J.C. 1989. "Medical Discourse" in Anthropological Context: Views of Language and Power. *Medical Anthropology Quarterly*, 3(2): 99–123.
- Kumar, K. 2005 (1991). *Political Agenda of Education: A Study of Colonialist and Nationalist Ideas*. New Delhi: Sage.
- Kumar, R. 2014. 'Why Family Medicine is a Good Career Choice for Indian Medical Graduates?' *Journal of Family Medicine and Primary Care*, 3(1). doi: 10.4103/2249-4863.130242
- Krishna, A. (2014), Examining the Structure of Opportunity and Social Mobility in India: Who Becomes an Engineer? *Development and Change*, 45: 1–28. doi:10.1111/dech.12072
- Krishnan, V. 2016. Most medical colleges show little interest in research: study. *The Hindu*, 21 April. <http://www.thehindu.com/todays-paper/tp-national/most-medical-colleges-show-little-interest-in-research-study/article8501007.ece> Accessed 23 September 2016.
- 2015. Private Practice: How Naresh Trehan became one of India's most influential doctor-businessmen. *The Caravan*, 1 February.
- Lambert, H. 2012. Medical pluralism and medical marginality: Bone doctors and the selective legitimization of therapeutic expertise in India. *Social Science & Medicine*, 74(7): 1029 - 1036. doi:10.1016/j.socscimed.2011.12.024
- Lazarus, E. S. 1986. Theoretical Considerations for the Study of the Doctor-Patient Relationship: Implications of a Perinatal Study. *Medical Anthropology Quarterly*, 2(1): 34–58.
- Lefebvre, B. 2008. The Indian Corporate Hospitals: Touching Middle Class Lives. In C. Jaffrelot & P. van der Veer (eds.), *Patterns of Middle Class Consumption in India and China*: 88-109. New Delhi: Sage.
- Liechty, M. 2003. *Suitably modern: making middle-class culture in a new consumer society*. Princeton: Princeton University Press.
- Leeming, W. 2001. Professionalization theory, medical specialists and the concept of "national patterns of specialization". *Social Science Information* 40(3): 455–485. doi: 10.1177/ 053901801040003005

- Levinson, B.A., D.E. Foley and D.C. Holland (eds.) 1996. *The Cultural Production of the Educated Person: An Introduction*. Albany: State University of New York Press.
- Lewin, E. And W.L. Leap, 1996. *Out in the Field: Reflections of Lesbian and Gay Anthropologists*. Champaign, IL: University of Illinois Press.
- Lock, M. and P. Kaufert. 2001. Menopause, local biologies, and cultures of aging. *American Journal of Human Biology*, 13(4): 494–504. doi:10.1002/ajhb.1081
- Lock, M. and D. Gordon (eds.). 1988. *Biomedicine Examined*. Dordrecht, The Netherlands: Kluwer Academic Publishers.
- Long, N.J. and H.L. Moore (eds.). 2013. *The Social Life of Achievement*. Oxford: Berghahn.
- Luke, H. 2003. *Medical Education and Sociology of Medical Habitus: "It's not about the Stethoscope!"* Dordrecht, The Netherlands: Kluwer Academic Publishers.
- Lukose, R. 2009. *Liberalization's Children: Gender, Youth, and Consumer Citizenship in Globalizing India*. Durham, NC: Duke University Press.
- Lynch, M. 2000. Against Reflexivity as an Academic Virtue and Source of Privileged Knowledge. *Theory, Culture and Society* 17(3): 26–54. doi: 10.1177/02632760022051202
- Macdonald, A. 2015. Revealing hope in urban India: breast cancer, vision and patient organisations. In N. Burke, E. Kampriani and H. Mathews (eds.), *Anthropologies of Cancer in a Transnational World*. Routledge: London.
- Malhotra, S. 2013. The dream factories. *Business Today*, 12 May. <http://www.businesstoday.in/magazine/cover-story/kota-coaching-institutes-brand-iit/story/194170.html> Accessed 23 September 2016.
- Manuel, T. 2015. India Produces 50,000 Doctors a Year. If Only Medical Education Were Better Regulated. *The Wire*, 28 August. <http://thewire.in/9427/medical-colleges-mci-mbbs/> Accessed 23 September 2016.
- Marcus, G. E. 1999. What Is at Stake – and Is Not – in the Idea and Practice of Multi-sited Ethnography. *Canberra Anthropology*, 22(2): 6–14. doi: 10.1080/03149099909508344
- 1995. Ethnography in/of the World System: The Emergence of Multi-sited Ethnography. *Annual Review of Anthropology*, 24: 95–117. doi: 10.1146/annurev.an.24.100195.000523

Marmot, M. and R. G. Wilkinson. 2006. *Social Determinants of Health*. Oxford: Oxford University Press.

Mehta, U. 1999. *Liberalism and Empire: A Study in Nineteenth-Century British Liberal Thought*. Chicago: University of Chicago Press.

Mehtal, Y. 2016. Surat girl ranks third in AIIMS entrance exam. *The Times of India*, 16 June. <http://timesofindia.indiatimes.com/city/surat/Surat-girl-ranks-third-in-AIIMS-entrance-exam/articleshow/52772673.cms> Accessed 23 September 2016.

Mendelsohn, O. and M. Vicziany. 1998. *The Untouchables : Subordination, Poverty and the State in Modern India*. Cambridge: Cambridge University Press.

Miller, H. 1973. *Medicine and Society*. London: Oxford University Press.

Mudur, G. 2016. Rise in India's health budget is "disappointing," say experts. *BMJ*, 352. doi: <http://www.bmj.com/content/352/bmj.i1338>

Moore, H. L. 2011. *Still Life: Hopes, Desires and Satisfaction*s. Cambridge and Malden, MA: Polity Press.

Mukherjee, S. 2013. The Perfect Last Day of Mr Sengupta. *Granta* 124: 35-42.

Munn, N. 1986. *The Fame of Gawa: A Symbolic Study of Value Transformation in a Massim Society*. Durham, NC: Duke University Press

Murthy, P., A. Sarin and S. Jain. 2013. International Advisers to the Bhore Committee: Perceptions and Visions for Healthcare. *Economic and Political Weekly*, 48(10): 71-77.

Mutha, S., J.I Takayama, with E.H. O'Neil. 1997. Insights into medical students' career choices based on third- and fourth-year students' focus-group discussions. *Academic Medicine*, 72(7): 635-40.

Nampoothiri, D.D. 2013. Confronting Social Exclusion: A Critical Overview of the CREST Experience. In S. Deshpande and U. Zacharias (eds.), *Beyond Inclusion: The Practice of Equal Access in Indian Higher Education*: 252-288. Routledge: New Delhi

Nanisetti, S. 2016. City boy tops AIIMS entrance. *The Hindu*, 15 June. <http://www.thehindu.com/news/cities/Hyderabad/city-boy-tops-aiims-entrance/article8730218.ece> Accessed 23 September 2016.

Narayan, K. 2012. *Alive in the Writing: Crafting Ethnography in the Company of Chekhov*. Chicago: University of Chicago Press.

Navarro, V. 1976. *Medicine under Capitalism*. New York: Prodist.

Nehru, J. 1958. *Jawaharlal Nehru's Speeches Vol.2: 1949-1953*. Delhi: The Publications Division.

- Nguyen, V-K. 2005. Antiretroviral Globalism, Biopolitics, and Therapeutic Citizenship. In A. Ong and S. J. Collier, (eds.), *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*: 124–144. Malden, MA: Blackwell.
- Nichter, M. 2008. *Global Health: Why Cultural Perceptions, Social Representations, and Biopolitics Matter*. Tucson: University of Arizona Press.
- O'Donnell, J.F. 2014. Introduction: The Hidden Curriculum – a Focus on Learning and Closing the Gap. In F.W. Hafferty and J.F. O'Donnell (eds.), *The Hidden Curriculum in Health Professional Education*: 1–20. Lebanon, NH: Dartmouth College Press.
- Otto, T. and R. Willerslev. 2013. “Value as theory”: Comparison, cultural critique, and guerilla ethnographic theory. *HAU: Journal of Ethnographic Theory* 3(1): 1–20.
- Oxfam India. 2015. Education to turn mirrors into windows. <https://www.oxfamindia.org/subpage/220> Accessed 5 November 2015.
- Page, E. 2005. Negotiation and Compromise: Gender and Government Elementary Education. In R. Chopra and P. Jeffery (eds.) *Educational Regimes in Contemporary India*: 178–196. New Delhi: Sage.
- Pandey, D. 2013. Child rape victim shifted to AIIMS as outrage spreads. *The Hindu*, 20 April. <http://www.thehindu.com/todays-paper/child-rape-victim-shifted-to-aiims-as-outrage-spreads/article4635436.ece> Accessed 23 September 2016.
- Pandhi, N. 2015. Clinical Trials. *The Caravan*, 1 October.
- Pandit, C.G. 1982. *My World of Preventive Medicine*. New Delhi: Leipzig Press.
- Panikkar, K.N., T. Joseph, Geetha G., M.A. Lal. 2011. *Quality, Access and Social Justice in Higher Education*. New Delhi: Pearson.
- Parry, J. 2005. Changing Childhoods in Industrial Chhattisgarh. In R. Chopra and P. Jeffery (eds.) *Educational Regimes in Contemporary India*: 276–298. New Delhi: Sage.
- 1999. Two Cheers for Reservation: The Satnamis and the Steel Plant. In J. Parry and R. Guha (eds.), *Institutions and Inequalities: Essays in honour of Andre Beteille*: 128–69. New Delhi: Oxford University Press.
- Patel, V., R. Parikh, S. Nandraj, P. Balasubramaniam, K. Narayan, V.K. Paul, A.K.S. Kumar, M. Chatterjee, and K.S. Reddy. 2015. Assuring health coverage for all in India. *Lancet*, 386: 2422–35.
- Pedersen, A.R. and D.M. Humle (eds.). 2016. *Doing Organizational Ethnography*. New York and Abingdon: Routledge.

- Pereira, B., G. Andrew, S. Pednekar, R. Pai, P. Pelto, and V. Patel. 2007. The explanatory models of depression in low income countries: Listening to women. *Journal of Affective Disorders*, 102: 209–218.
- Petryna, A. 2002. *Life Exposed: Biological Citizens after Chernobyl*. Princeton: Princeton University Press.
- Phadke, A. 2016. Regulation of Doctors and Private Hospitals in India. *Economic and Political Weekly*, 41(6): 46–55.
- Phalkey, J. 2013. Introduction: Science, History, and Modern India. *Isis*, 104(2): 330–336.
- Pinto, S. 2015. “The Tools of Your Chants and Spells”: Stories of Madwomen and Indian Practical Healing. *Medical Anthropology*, 35(3): 263–277. doi: <http://dx.doi.org/10.1080/01459740.2015.1081902>
- 2008. *Where There Is No Midwife: Birth and Loss in Rural India*. Oxford: Berghahn.
- 2004. Development without Institutions: Ersatz Medicine and the Politics of Everyday Life in North India. *Cultural Anthropology*, 19(3): 337–364.
- Placebo*. Directed by A. Kumar. 2014. Storyteller Ink. Netflix, 2016.
- Pollock, D. 1996. Training Tales: U.S. Medical Autobiography. *Cultural Anthropology*, 11(3): 339–361.
- Porecha, M. 2014. Do you still have a family physician? *dna*, 23 February. <http://www.dnaindia.com/health/report-do-you-still-have-a-family-physician-1964306> Accessed 23 September 2016.
- Powell-Jackson T., A. Acharya, and A. Mills. 2013. An assessment of the quality of primary health care in India. *Economic and Political Weekly*, 48(19): 53–61.
- Premchand, M. 1910. *Bade Bhai Sahab*. Available at: <https://www.scribd.com/doc/6691922/Bade-Bhai-Sahab>
- Priyam, M. 2015. *Contested politics of educational reform in India : aligning opportunities with interests*. New Delhi: Oxford University Press.
- Qadeer, I., K. Sen, and K. R. Nayar (eds.). 2001. *Public Health and the Poverty of Reforms: The South Asian Predicament*. New Delhi: Sage.
- Quazi, A.H. 2016. AIIMS in bag, test toppers set new goals: Neurosurgery, research. *Hindustan Times*, 15 June. <http://www.hindustantimes.com/education/aiims-in-bag-test-toppers-set-new-goals-neurosurgery-research/story-moYwSyIjiuMvTDfQjJsJNL.html> Accessed 23 September 2016.

- Raina, D. and S. Irfan Habib. 2004. *Domesticating Modern Science: A Social History of Science and Culture in Colonial India*. Chennai: Tulika.
- Rajshekhar, M. 2015. High patient inflow, corruption, nepotism and talent exodus: The problems that have plagued AIIMS. *The Economic Times*, 12 March. http://articles.economictimes.indiatimes.com/2015-03-12/news/60048160_1_new-aiims-delhi-aiims-aiims-metro-station Accessed 23 September 2016.
- Ram, K. 2010. Class and the clinic: the subject of medical pluralism and the transmission of inequality. *South Asian History and Culture*, 1(2), 199-212.
- Ramalingaswami, V. 1975. *Medicine, health and development*. Ninth Jawaharlal Nehru Memorial Lecture, 13 November 1975. New Delhi.
- Rao, K.D., S. Ramani, S. Murthy, I. Hazarika, N. Khandpur, M. Choksi, S. Khanna, M. Vujicic, P. Berman, and M. Ryan. 2010. Health worker attitudes toward rural service in India: Results from qualitative research. Health, Nutrition, and Population Unit, Human Development Network, World Bank. <http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/HealthWorkerAttitudesTowardRuralServiceinIndia.pdf>
- Rao, S. and S. Naik. 2016. Supreme Court directive on making NEET compulsory is move in the right direction. *The Indian Express*, 10 May. <http://indianexpress.com/article/opinion/columns/neet-mbbs-supreme-court-medical-exam-aipmt-2792355/> Accessed 23 September 2016.
- Rao, U. 2013. Biometric Marginality: UID and the Shaping of Homeless Identities in the City. *Economic and Political Weekly*, 48(13): 71-77.
- Rapp, R. 1988. Chromosomes and Communication: The Discourse of Genetic Counseling. *Medical Anthropology Quarterly*, 2(2): 143-157. doi: 10.1525/maq.1988.2.2.02a00040
- Rashid, T. 2006. Dr Ramadoss plays the boss, pushes AIIMS chief to brink. *The Indian Express*, 15 June. <http://archive.indianexpress.com/news/dr-ramadoss-plays-the-boss-pushes-aiims-chief-to-brink-----/6562/o> Accessed 23 September 2016.
- Ravi Rajan, S. 2005. Science, State, and Violence: An Indian Critique Reconsidered. *Science as Culture*, (14):1-17.
- Rawal, U. and Quazi, D. 2015. Kota suicides: In this coaching hotspot, stress snuffs out lives. *Hindustan Times*, 19 October. <http://www.hindustantimes.com/education/kota-suicides-in-this-coaching-hotspot-stress-snuffs-out-lives/story-prJar3TIYa4RHMkxmoZmlK.html> Accessed 23 September 2016.

- Robinson, F. 1996. Islam and the impact of print in South Asia. In N. Crook (ed), *The Transmission of Knowledge in South Asia: Essays on Education, Religion, History, and Politics*: 62–97. New Delhi: Oxford University Press.
- Rose, N. 2006. *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton: Princeton University Press.
- Rose, N. and C. Novas. 2005. Biological Citizenship. In A. Ong and S. J. Collier, (eds.), *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*: 439–463. Malden, MA: Blackwell.
- Rosenberg, C.E. 2007. *Our Present Complaint: American Medicine, Then and Now*. Baltimore: Johns Hopkins University Press.
- Ruddock, 2015. Incorrect Dosage: India's blinkered preference for specialist doctors. *The Caravan*, 1 November.
- Saez, L. and A. Sinha. 2010. Political Cycles, Political Institutions and Public Expenditure in India, 1980–2000. *British Journal of Political Science*, 40(1): 91–113.
- Sarangapani, P.M. 2014. Knowledge, curricula, and teaching methods: the case of India. *Revue internationale d'éducation de Sèvres*. <http://ries.revues.org/3851>
- Scheper-Hughes, N. 1989. *Death Without Weeping: The Violence of Everyday Life in Brazil*. Berkeley: University of California Press.
- Scheper-Hughes, N. and M. Lock. 1986. Speaking "Truth" to Illness: Metaphors, Reification, and a Pedagogy for Patients. *Medical Anthropology Quarterly*, 17(5): 137–140.
- Seth, D.L. 1995. The Great Language Debate. In B.Parekh and U. Baxi (eds.), *Crisis and Change in Contemporary India*: 187–215. New Delhi: Sage.
- Sethi, A. 2015. The mystery of India's deadly exam scam. *The Guardian*, 17 December. <http://www.theguardian.com/world/2015/dec/17/the-mystery-of-indias-deadly-exam-scam> Accessed 23 September 2016.
- Sethi, N. 2016. Parliamentary Standing Committee report on corruption in the hospital has no foundation: AIIMS. *Business Standard*, 3 June. http://www.business-standard.com/article/current-affairs/parliamentary-panel-report-on-corruption-baseless-aiims-116060300042_1.html Accessed 23 September 2016.

- 2014. Harsh Vardhan upholds power to remove Chaturvedi from AIIMS. *Business Standard*, 25 September. http://www.business-standard.com/article/economy-policy/harsh-varadhan-upholds-power-to-remove-chaturvedi-from-aiims-114092500037_1.html Accessed 23 September 2016.
- Shah, A. and S. Shneiderman (guest eds.). 2013. Toward an Anthropology of Affirmative Action. *Focaal*, 65: 3-162.
- Shah, A.M. 1991. Job Reservations and Efficiency. *Economic and Political Weekly*, 26(29): 1732-1724.
- Sharma, D.C. 2015. India still struggles with rural doctor shortages. *The Lancet*, 386(10011): 2381-2382. doi: 10.1016/S0140-6736(15)01231-3
- Sheikh, K., S. Mondal, P. Patanwar, B. Rajkumari, T. Sundararaman. 2016. What rural doctors want: a qualitative study in Chhattisgarh state. *Indian Journal of Medical Ethics*, 1(3): 138-144.
- Sheikh, K., B. Rajkumari, K. Jain, K. Rao, P. Patanwar, G. Gupta, K. R. Antony, and T. Sundararaman. 2012. Location and vocation: why some government doctors stay on in rural Chhattisgarh. *International Health* 4:192-199. doi:10.1016/j.inhe.2012.03.004
- Sheikh, K. and J. Porter. 2011. Disempowered doctors? A relational view of public health policy implementation in urban India. *Health Policy and Planning*, 26: 83-92. doi:10.1093/heapol/czq023
- Sheikh, K. and A. George (eds.). 2010. *Health Providers in India: On the Frontlines of Change*. Routledge: New Delhi.
- Shem, S. 1978. *House of God*. London: Black Swan.
- Shetty, D. 2015. Fixing Healthcare. *Seminar*, November. http://www.india-seminar.com/2015/675/675_devi_shetty.htm Accessed 23 September 2016.
- Sinclair, S. 1997. *Making doctors: An institutional apprenticeship*. Oxford: Berg.
- Singh, B [Baldev] (ed.). 1988. Jawaharlal Nehru on Science and Society: a collection of his writings and speeches. New Delhi: Nehru Memorial Museum and Library.
- Singh, B [Brighupati]. 2015a. *Poverty and the Quest for Life: Spiritual and Material Striving in Rural India*. Chicago: University of Chicago Press.
- 2015b. Reply to Comments in Book Forum. *Somatosphere*, 13 March. <http://somatosphere.net/forumpost/reply-to-comments>

- Singh, J. 2016. Budget allocation for health less than half of 12th Plan promises. *livemint*, 28 April.
<http://www.livemint.com/Politics/BtgaCDbm8HWoAaRojrGfMN/Budget-allocation-for-health-less-than-half-of-12th-Plan-pro.html> Accessed 23 September 2016.
- Sivaji. Directed by S. Shankar. 2007. AP International, 2007. DVD.
- Sood, R. and B.V. Adkoli. 2000. Medical Education in India – Problems and Prospects. *Journal of the Indian Academy of Clinical Medicine*, 1(3): 210–212.
- Sood, R. and T. Singh. 2012. Assessment in medical education: Evolving perspectives and contemporary trends. *The National Medical Journal of India* 25(6): 357–364.
- Sruthijith, K.K. 2015. Delhi's upscale hospitals are turning away the poor in whose name they got land, subsidies. *The Huffington Post*, 13 September.
http://www.huffingtonpost.in/2015/09/13/delhi-dengue-hospitals_n_8128704.html Accessed 20 September 2016.
- Stafford, C. 2009. Numbers and the natural history of imagining the self in Taiwan and China. *Ethnos*, 74(1): 110–126. doi: 10.1080/00141840902751238
- Still, C. 2013. “They have it in their stomachs but they can't vomit it up”: Dalits, reservations, and “caste feeling” in rural Andhra Pradesh. *Focaal*, 65: 68–79. doi: <http://dx.doi.org/10.3167/fcl.2013.650107>
- Stonington, S. 2011. Facing death, gazing inward: end-of-life and the transformation of clinical subjectivity in Thailand. *Culture, Medicine and Psychiatry*, 35(2): 113–133. doi: 10.1007/s11013-011-9210-6
- Street, A. 2014. *Biomedicine in an Unstable Place: Infrastructure and Personhood in a Papua New Guinean Hospital*. Durham and London: Duke University Press.
- 2012. Affective infrastructure: hospital landscapes of hope and failure. *Space and Culture*, 15(1): 44–56. doi: 10.1177/1206331211426061
- Street, A. and S. Coleman. 2012. *Introduction: Real and Imagined Spaces*. *Space and Culture*, 15(1): 4–17. doi: 10.1177/1206331211421852
- Subramanian, A. 2015. Making Merit: The Indian Institutes of Technology and the Social Life of Caste. *Comparative Studies in Society and History*, 57(2): 291–322. doi:10.1017/S0010417515000043
- Sukumar, N. 2013. Quota's Children: The Perils of Getting Educated. In S. Deshpande and U. Zacharias (eds.), *Beyond Inclusion: The Practice of Equal Access in Indian Higher Education*: 205–221. Routledge: New Delhi.

- Sundararaman, T., I. Mukhopadhyay, V.R. Muraleedharan. 2016. No Respite for Public Health. *Economic and Political Weekly*, 51(16).
- Swades*. Directed by Ashutosh Gowariker. 2004. Moserbaer, 2006. DVD.
- Szakolczai, A. 2015. Liminality and Experience: Structuring Transitory Situations and Transformative Events. In A. Horvath, B. Thomassen, and H. Wydra (eds.), *Breaking Boundaries: Varieties of Liminality*: 11–38. New York and Oxford: Berghahn.
- Taussig, M. 1980. Reification and the Consciousness of the Patient. *Social Science & Medicine*, 14(1): 3–13.
- Taylor, J.S. and C. Wendland. 2014. The Hidden Curriculum in Medicine’s “Culture of No Culture”. In F.W. Hafferty and J.F. O’Donnell (eds.), *The Hidden Curriculum in Health Professional Education*: 53–62. Lebanon, NH: Dartmouth College Press.
- Tharu, S., M.M. Prasad, R. Pappu, and K. Satyanarayana. 2007. Reservations and the Return to Politics. *Economic and Political Weekly*, 42(49): 39–45.
- The Hindu*. 2010. Protest against denial of reservation at AIIMS. 3 October. <http://www.thehindu.com/todays-paper/tp-national/tp-newdelhi/protest-against-denial-of-reservation-at-aiims/article810496.ece> Accessed 23 September 2016.
- The Lancet*. 2011. Rational reform to medical education in India. Vol 377(9773). doi: [http://dx.doi.org/10.1016/S0140-6736\(11\)60483-2](http://dx.doi.org/10.1016/S0140-6736(11)60483-2) Accessed 16 March 2016.
- The Statesman. 2015. AIIMS faculty demands drive to fill SC, ST posts. 15 October. <http://www.thestatesman.com/news/delhi/aiims-faculty-demands-drive-to-fill-sc-st-posts/96957.html> Accessed 26 September 2016.
- Thomassen, B. 2015. Thinking with Liminality: To the Boundaries of an Anthropological Concept. In A. Horvath, B. Thomassen, and H. Wydra (eds.), *Breaking Boundaries: Varieties of Liminality*: 39–58. New York and Oxford: Berghahn.
- Turner, B.S. 1987. *Medical Power and Social Knowledge*. London: Sage.
- Turner, S. 2010. The silenced assistant: Reflections of invisible interpreters and research assistants. *Asia Pacific Viewpoint*, 51: 206–219.
- Turner, V. 1967. *The Forest of Symbols: Aspects of Ndembu Ritual*. Ithaca and London: Cornell University Press.
- Unnikrishnan, V. 2016. AIIMS director Mishra in trouble: RS MPs seek privilege motion. *Catch News*, 3 August. <http://www.catchnews.com/health-news/aiims->

director-misra-in-trouble-rs-mps-seek-privilege-motion-1470225969.html/fullview Accessed 23 September 2016.

van Amstel, H. and S. van der Geest. 2004. Doctors and retribution: the hospitalisation of compensation claims in the Highlands of Papua New Guinea. *Social Science & Medicine*, 59(10): 2087–2094. doi: <http://dx.doi.org/10.1016/j.socscimed.2004.03.011>

van der Geest, S. 2003. Confidentiality and Pseudonyms: A fieldwork dilemma from Ghana. *Anthropology Today*, 19 (1): 14–18.

van der Geest, S. and K. Finkler. 2004. Hospital Ethnography: Introduction. *Social Science & Medicine*, 59(10): 1995–2001. doi:10.1016/j.socscimed.2004.03.004

van Gennep, A. 1961. *The Rites of Passage*. M.B. Vizedom and G.L. Caffee (trans.). Chicago: University of Chicago Press.

Van Hollen, C. 2003. *Birth on the Threshold: Childbirth and Modernity in South India*. Berkeley: University of California Press.

Varma, P. 2007. *The Great Indian Middle Class*. New Delhi: Penguin.

Venkatesan, V. The Dynamics of Medicos' Anti-Reservation Protests of 2006. In K. Sheikh and A. George (eds.) *Health Providers in India: On the Frontlines of Change*: 142–157. Routledge: New Delhi.

Visvanathan and Sethi. 1998. *Foul Play: chronicles of corruption*. New Delhi: Banyan Books.

Weisz, G. 2005. *Divide and Conquer: A Comparative History of Medical Specialization*. Oxford: Oxford University Press.

Wendland, C.L. 2010. *A Heart for the Work: Journeys Through an African Medical School*. Chicago: The University of Chicago Press.

Wilce, J. M. 2009. Medical Discourse. *Annual Review of Anthropology*, 38: 199–215. doi: 10.1146/annurev-anthro-091908-164450

Wilson, C. 2011. The social transformation of the medical profession in urban Kerala: Doctors, social mobility and the middle classes. In H. Donner (ed.), *Being Middle Class in India: A way of life*: 139–161. Routledge: Abingdon & New York.

Wind, G. 2008. Negotiated interactive observation: Doing fieldwork in hospital settings. *Anthropology and Medicine*, 15(2): 79–89. doi: 10.1080/13648470802127098

Wright, S. (ed.). 1994. *Anthropology of Organizations*. London: Routledge.

Zacharias, U. 2013. To Race with the Able? Soft Skills and the Psychologisation of Marginality. In S. Deshpande and U. Zacharias (eds.), *Beyond Inclusion: The Practice of Equal Access in Indian Higher Education*: 289–327. Routledge: New Delhi

Zaman, S. 2004. Poverty and Violence, Frustration and Inventiveness: Hospital Ward Life in Bangladesh. *Social Science & Medicine*, 59(10): 2025–2036.
doi:10.1016/j.socscimed.2004.03.007